



**North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

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On behalf of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, we are pleased to offer for comment North Carolina's **Substance Abuse Prevention and Treatment Block Grant** application for fiscal year 2014. Each year the Division submits an application to the Substance Abuse and Mental Health Services Administration (SAMHSA) for funds that will provide prevention, early intervention, treatment and recovery supports to individuals at risk for or with a substance use disorder. These funds, which typically amount to more than \$35 million per year, are integral to the development, maintenance and expansion of services in North Carolina. They are intended to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families and communities impacted by substance use disorders and associated problems. Specifically, the funds are directed toward four purposes:

- ❧ Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- ❧ Fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- ❧ Fund primary prevention - universal, selective and indicated prevention activities and services for persons not identified as needing treatment.
- ❧ Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan the implementation of new services on a nationwide basis.

Interested persons and agencies are invited to provide comments and thoughts to improve this plan. Please email comments to DeDe Severino at dede.severino@dhhs.nc.gov by February 15, 2014. We appreciate your consideration and feedback as we continue to strive towards better addressing and meeting the needs of individuals and communities in our state.

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**Substance Abuse Prevention and Treatment
Assessment and Plan**

Block Grant Application

Fiscal Years 2014 – 2015

US Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Narrative Question: Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) of the North Carolina Department of Health and Human Services is the Single State Agency for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the State Mental Health Agency for the Community Mental Health Services (CMHS) Block Grant. It consists of the Director's Office and four sections, each of which is subdivided into teams based on functions.

The Community Policy Management (CPM) Section is primarily responsible for the oversight of services delivered by Local Management Entities/Managed Care Organizations (LME/MCOs), the Division's intermediaries at the local level. The CPM Section consists of the Employee Assistance Program, the Quality Management Team, the Best Practice and Community Innovations Team, the Local Management Entity Systems Performance Team, the Justice System Innovations Team and the Prevention and Early Intervention Team, and is responsible for the management of the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants. Each of the teams in the CPM section have staff with expertise in each of the populations of focus who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood. The section has a state-funded System of Care Coordinator serving children and youth with Serious Emotional Disorders (SED). Each Local Management Entity/Managed Care Organization has a state-funded System of Care Coordinator and a community collaborative composed of family members, youth, state and community representatives that oversee supports and services for children and youth with SED. The section also has a designated Housing Specialist who provides oversight to Housing Specialists at each LME/MCO, in addition to staff with expertise in evidence-based practices and peer support.

The Resource and Regulatory Management Section is responsible for fiscal monitoring, accountability and regulatory compliance, support of information technology and contracts management. It is made up of the Information Systems Team, Financial Operations and the Accountability Team.

The Advocacy and Customer Service Section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights protection for individuals served through the system. It is made up of two teams: the Customer Service and Community Rights Team and the Consumer Empowerment Team.

The Operations Support Section is responsible for planning, rule and policy development, media relations, training and communication with external stakeholders. Its teams are the Planning Team, the Division Affairs Team and the Communications and Training Team.

Substance abuse treatment and prevention and mental health services were formerly provided directly by service providers (individuals) employed by area/county programs. With the 2001 Mental Health Reform legislation passed by the NC General Assembly, the focus of area programs shifted from direct service provision to the management of the local service delivery system. These Local Management Entities (LMEs) began contracting with providers for the delivery of services in their catchment areas. Between 2001 and 2010, the number of LMEs was incrementally reduced from 48 to 23. In April 2005, the state piloted the 1915 (b) Freedom of Choice Waiver /(c) Innovations Home and Community Based Services (HCBS) Managed Care Waiver with one LME. Under these waivers, Medicaid services are funded through capitated Pre-paid Inpatient Health Plans (PIHP) that allow the MCO to have more flexibility in service delivery. Due to the success of the pilot, in December 2009, DHHS submitted a waiver amendment to CMS designed to expand the 1915 (b)/(c) waiver statewide over a period of several years. Numerous mergers between LMEs have occurred since then, resulting to date in 11 LME/MCOs covering all 100 counties. DMH/DD/SAS and the Division of Medical Assistance (the state Medicaid agency) jointly administer the LME/MCOs.

The SSA supports a comprehensive system of care to enable individuals that it serves to live in communities of their choosing and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced services (Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, Community Support Team, Intensive In-Home, Adolescent Day Treatment), opioid/medication assisted therapies, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people involved in the criminal justice system. A robust array of gender-specific/gender responsive services are available for women, including women who are pregnant and/or have dependent children. In addition, mobile and walk-in crisis services, various levels of detoxification, residential and inpatient treatment services are available throughout the state. The continuum further includes evidence-based practices included in the state's Medicaid-reimbursable service definitions, such as Therapeutic Foster Care, Multi-Systemic Therapy and Family Functional Therapy for children and youth and Assertive Community Treatment, Supported Housing and Supported Employment. Other evidence-based practices are provided via existing service definitions by some LME/MCOs. For example, an ACT team may implement an integrated dual disorders treatment model to better serve individuals with co-occurring mental illness and addiction. Seeking Safety or trauma-informed cognitive behavioral therapies may be utilized under the SAIOP or SACOT service definition for those individuals who have experienced trauma in their lives. LME/MCOs have also developed and implemented, with DMH/DD/SAS approval, alternate service definitions such as peer and recovery supports, transition services, wellness and living skills, to create a more robust continuum of care. Telehealth/telemedicine is utilized in areas that have shortages of therapists and/or psychiatrists. Community Prevention Resources (CPRs), funded through the Substance Abuse Prevention and Treatment Block Grant and the State's 2004 Strategic Prevention Framework/State Incentive Grant provide additional resources.

DMH/DD/SAS receives funds from the General Assembly for crisis services (mobile crisis teams, walk-in crisis and psychiatric after-care and crisis intervention teams) geared towards the reduction of hospitalizations, use of emergency department services and jail diversion for people with substance use and mental health disorders.

The United States Department of Commerce (2012) reports that North Carolina is currently home to the third largest active military population in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. An additional 45,000 soldiers, marines, and airmen and women live in all 100 counties of North Carolina and serve in the National Guard or Reserves. North Carolina's veteran population is even larger, consisting of nearly 800,000 veterans, placing the state fifth in military retirees and ninth in veteran population in the country. More than 100,000 children and adolescents of active members/National Guard/Reserves live in North Carolina and about 35% of the state's population is in the military, a veteran, spouse, survivor, parent or dependent of someone connected to the military. (*Honoring Their Service: A Report of the NC Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families, January 2011*).

The Division coordinates with the North Carolina National Guard, Veterans Administration, Tricare and the Citizen Soldier Support Program, as well as with the NC General Assembly, the Division of Vocational Rehabilitation Services, Department of Public Safety, Department of Public Instruction, Department of Labor, Governor's Institute, Area Health Education Programs, state universities, provider organizations and faith-based organizations on various initiatives that address active duty military, veterans, National Guard members, the Reserve and family members of the military. In 2008, SAMHSA invited representatives of state mental health and substance abuse agencies to join with the Department of Defense (DOD) and the Department of Veterans Affairs (VA) to begin to construct a behavioral health response for combat veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Upon returning from this initial national summit, DMH/DD/SAS, with the approval of the NC DHHS, initiated work utilizing a strategic plan that strengthens collaboration, coordination and resource sharing between the State of North Carolina, federal military partners and service members and their families. The NC FOCUS on Service Members, Veterans and Their Families is a collaborative initiative involving state government, the VA, the Department of Defense and other organizations. The group, co-chaired by DMH/DD/SAS and the VA, began with the purpose of bringing together key leaders and stakeholders throughout the state to share information and promote best practices in the service provision for service members, veterans and their families. The group continues to meet to discuss the continuum of care for this population, the timely provision of mental health and substance abuse services, and to develop new ideas to meet their needs. The project has expanded its original focus on combat veterans to veterans of all eras living in the state.

NC FOCUS is staffed on behalf of DMH/DD/SAS by the Governor's Institute on Substance Abuse and promotes evidence-based practices in the screening, assessment and treatment of active and reserve components, veterans and military family members in North Carolina, including traumatic brain injury (TBI). NC FOCUS has successfully competed to participate in three national policy academies supported by SAMHSA where the team works with national leaders to continually refine the North Carolina Plan. The North Carolina process to support veterans has received national recognition and has provided technical assistance to many other states. In 2011, "Honoring Their Service: A Report of the North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their

Families” was presented to the Legislative Oversight Committee on Mental Health. The report identifies potential gaps in services for service members experiencing mental health problems such as post-traumatic stress, substance use disorders and TBI. The Institute of Medicine (IOM) report and the ongoing work of the NC FOCUS group have been supported with technical assistance and financial supported by SAMHSA.

In addition to contracting with the 11 LME/MCOs for the delivery of prevention and treatment services, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

- ***Governor’s Institute on Substance Abuse*** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families.
- ***Oxford House*** – this contract allows for the continuation of substance abuse recovery home management services by opening new houses, administering loans and serving and mentoring re-entering substance users in their transition from incarceration.
- ***NC State University, Center for Urban Affairs and Community Services*** – this contract provides for the management of the web-based Treatment Outcomes and Program Performance System (NC TOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.
- ***University of North Carolina, School of Social Work, Behavioral Healthcare Resource Program*** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance abuse prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state.
- ***NC Substance Abuse Professional Practice Board*** – The NC Substance Abuse Professional Practice Board (NCSAPPB) will continue to register, certify, approve and issue associate-level licensed clinical addictions specialists and credentialed substance abuse professionals in

accordance with state and federal requirements to improve substance abuse related services for consumers throughout North Carolina.

- **NC Division of Public Health** – this multi-year inter-departmental agreement augments HIV/Early Intervention services provided through contracts with the LME/MCOs and is integral to North Carolina's adherence to the requirements for HIV designated states. The Division of Public Health provided testing, counseling services and therapeutic interventions to over 3900 individuals in SFY12.
- **Alcohol/Drug Council of North Carolina** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire state. This agency is also responsible for the Perinatal Substance Use Project, which includes screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal and CASAWORKS Initiative on a weekly basis, as well as training and technical assistance to agencies working with women who are pregnant or parenting on issues related to substance use.

Step 2: Identify the unmet service needs and critical gaps within the current system

Narrative Question: This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority. The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Approximately 7.03 percent of all North Carolinians aged 12 or older are expected to have Substance Use Disorders (SUDs). The prevalence estimates for North Carolina are slightly lower than national averages and vary by age: 5.89 percent for those between the ages of 12 - 17 years; 17.44

percent for young adults aged 18 to 25; and 5.33 percent for adults aged 26 and up. (Data Source: <http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsaeTables2011.pdf>, Table 20 - Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year, by Age Group and State: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data – Revised March 2012.)

In 2012, North Carolina had an estimated total population of 9,781,022 people, making it the tenth largest state in the United States. Given the above prevalence rates, it is estimated that of the 769,368 youth between the ages of 12 – 17, 5.89 percent or about 45,321 youth will have a substance use disorder. Young adults between the ages of 18-25 have a much higher incidence of substance use; accordingly of those 1,093,393 young adults, approximately 191,211 will have a substance use disorder. Adults ages 26 and older have the lowest prevalence rate; given the population of over five million adults, 268,822 will have a substance use disorder. (Data Source: NC Office of State Budget and Management (OSMB) website-http://www.osbm.state.nc.us/demog/countytotals_singleage_2012.html)

The table below illustrates, by age range, the estimated general population, as well as the approximate uninsured population in North Carolina as of July 2012. Using the prevalence percentages from the National Survey on Drug Use and Health, estimates of prevalence are presented for both the general population, as well as the uninsured. In that federal funds are primarily utilized for individuals who are uninsured, penetration rates are presented for the uninsured population. While it is believed these numbers are a more accurate indication of the impact of state and block grant funds, it should be noted that prevalence may differ slightly for the uninsured population, and block grant funds may be utilized for individuals with some form of coverage; i.e., Medicaid, if the necessary service is not offered by the Medicaid State Plan Amendment.

Age Range	12-17	18-25	26-64
Population number	769,458	1,096,393	5,043,565
Prevalence percentage	5.89%	17.44%	5.33%
Prevalence of SUD – general population	45,321	191,211	268,822
Uninsured percentage	8.3%	19.4%	20.9%
Uninsured population number	64,081	213,168	1,052,860
Prevalence of SUD - uninsured population	3,774	37,176	56,117
		93,293	
Number served with public funds	509	29,424	
Penetration rate	13.4%	31.5%	

(Data Source: NC Office of State Budget and Management (OSMB) website SFY 2013 Uninsured Population - http://www.osbm.state.nc.us/demog/countytotals_singleage_2012.html).

While the numbers in the table above are an unduplicated count of individuals who received services for a substance use disorder, the duplicated number of persons served was 1496 youth between the ages of 12 -17 and slightly over 84,000 adults during state fiscal year 2012. (Data Sources: NC Alcohol and Drug Abuse Treatment Centers Annual Statistical Report, Fiscal Year 2012 and NC Local Management Entity Annual Statistics and Admission Report, Fiscal Year 2012.)

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is now statewide. All 100 counties are part of a catchment area covered by one of eleven local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, injecting drug users, etc.

Under the direction of North Carolina's newly elected governor and newly appointed secretary of the Department of Health and Human Services, it appears that North Carolina may soon apply for an 1115 waiver that would impact the behavioral health service delivery system. While specific plans are still being formulated, it has been announced that the publicly-funded behavioral health system will be managed by three to four comprehensive care entities, which could replace the eleven current LME/MCOs.

The following sections describe the need and gaps identified within the service system in North Carolina. It is important to note that while we will attempt to address these gaps as much as possible, much effort will be placed on improving outcomes of those served. Given the continued growth of North Carolina's population, the state's decision to not expand Medicaid coverage per the Affordable Care Act, possible changes from a 1915 (b)/(c) waiver to an 1115 waiver environment and decreases in federal funding, the focus will be maintenance of the number of service recipients and improved outcomes for those participants.

The Public Health Service Act requires the substance abuse block grant to address prevention and early intervention. In addition, it also specifies populations that must be served with grant funds. These are:

- persons who use drugs intravenously (IDU);
- pregnant women with substance use and women with substance use who also have dependent children
- individuals with tuberculosis
- persons with or at risk for HIV/AIDS who are in treatment for a substance use disorder

North Carolina ranked tenth among the 50 states in AIDS cases diagnosed in 2010 (the most recent year available for national comparisons) and ninth in the nation in 2009 for estimated persons living with AIDS. According to the *NC Epidemiological Profile for STD/HIV Prevention and Care Planning (North Carolina Department of Health and Human Services, Division of Public Health, Epidemiology Section Communicable Disease Branch, December 2012)*, an estimated 36,500 people were living with HIV/AIDS in North Carolina as of December 31, 2012. The total number of new HIV diagnoses in 2011 was 1,563, with the highest rate of new HIV diagnoses among adult and adolescent African American males. In 2010, HIV/AIDS was listed as the seventh leading cause of death for North Carolina adults aged 25 to 44 years old. As North Carolina has been identified as a "designated state" by SAMHSA, at least

five percent of substance abuse block grant funding is spent on HIV early intervention services for people who are participating in treatment for a substance use disorder. This funding is distributed to the LME/MCOs who then contract with providers. In addition, the Division also has a Memorandum of Understanding with the Division of Public Health, Communicable Disease Section, to provide testing and intervention services for persons that have substance use disorders. In 2011, injecting drug use accounted for eight percent of HIV disease cases for adult/adolescent females and six percent of adult/adolescent males.

The North Carolina Institute of Medicine (NCIOM) is an independent, quasi-state agency that was chartered by the North Carolina General Assembly in 1983 to provide balanced, nonpartisan information on issues of relevance to the health of North Carolina's population. In 2007, the North Carolina General Assembly enacted Session Law 2007-323 that led to the creation of the Task Force on Substance Abuse Services facilitated by the NCIOM. Funded with SAPTBG funds, the Task Force on Substance Abuse Services convened a steering committee that included representation from the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. In collaboration with the Division of Public Health and the NC Department of Health and Human Services, the NCIOM convened a Task Force on Prevention that met between 2008 and 2009 to develop the NC Prevention Plan. Both Task Forces recommended the development of a comprehensive substance abuse plan that would have prevention at its core with children, adolescents, young adults and their parents as priority targets.

The State has also identified juveniles and adults with substance use disorders who are involved with the law as a population of focus. According to the North Carolina Division of Alcoholism and Chemical Dependency Programs, approximately 90% of the criminal offenders who enter the prison system have substance abuse problems. (*North Carolina Division of Alcoholism and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report, 2006-2007. http://www.doc.state.nc.us/Legislative/2008/2006-07_Annual_Legislative_Report.pdf. Published March 2008.*) Treatment Accountability for Safer Communities (TASC) services continue to be delivered in all 100 counties for adults with SUDs by the NC TASC Network through the TASC Regional Coordinating Entities. More than two out of five youth in the state's juvenile justice system are in need of further assessment or treatment services for substance abuse, as noted in the 2007 annual report from the North Carolina Department of Juvenile Justice and Delinquency Prevention. (*http://www.ncdjdp.org/resources/pdf_documents/annual_report_2007.pdf. Published March 2007.*) The Division and the Department of Juvenile Justice and Delinquency Prevention have been in collaboration with each other since 1997 to provide services to youth involved with juvenile justice and to develop a program of service delivery for youth who are involved in the justice system in partnership with their families.

Community integration/recovery support is another area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals' recovery. Planning efforts currently include the revision of the Supported Employment service definition that would be available to individuals with a substance use disorder in need of that type of service. The Division will promote the utilization of this service as necessary and appropriate for the population. The state has an ongoing contract with Oxford House Inc. to provide

housing for people in recovery and has set aside \$100,000 for the support of statewide consumer housing through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention and treatment for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Abuse Initiative is composed of 21 specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

As stated above, North Carolina, like many states, has seen an increase in the use of painkillers, creating a higher demand for opioid treatment programs or medication-assisted therapies. There are currently 45 opioid treatment programs in the state, of which approximately 20 are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs.

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total of 116,000 are in the active military, while a total of 766,000 are veterans and 190,896 are dependents of service members. DMH/DD/SAS serves the needs of the military primarily through the NC Focus on Service Members, Veterans and Their Families, a project that it supports and funds through the SABG. NC Focus promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families.

The State Epidemiological Outcomes Workgroup (SEOW) for the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) that was funded by the Center for Substance Abuse Prevention in 2005 further identified alcohol related deaths and under-age drinking as target areas for the state's SPF/SIG project. The state epidemiological profile produced by the SEOW also identified four

other high-ranked areas of focus: (1) driving while impaired (DWI) disposed cases/convictions for those under 21; (2) deaths from drug overdose; (3) possession of a controlled substance in violation of the law among students grades K-12 and under; and (4) adults aged 18 or older arrested for drug law offenses.

The Substance Abuse Block Grant will continue to provide universal, selective and indicated prevention intervention and early intervention activities in community settings. It will also continue to provide treatment to the priority groups enumerated above, emphasizing the use of trauma-informed care and evidence-based practices.

Table 1 Steps 3, 4: Priority Area and Annual Performance Indicators

Table 1 *Priority Areas and Annual Performance Indicators*

1) Enter the name of a Priority Area (based on an unmet service need or a critical gap). Each step that follows will be repeated for each Priority Area identified.

2) Select a Priority Type by checking one of the boxes:

SAP—substance abuse prevention

SAT—substance abuse treatment

3) For treatment, select one of the required populations by checking one of the boxes listed. A minimum of one goal is required for each:

PWWDC—Substance abusing pregnant women

PWWDC--Women with dependent children in need of treatment

IVDUs—Intravenous drug users

HIV EIS—Persons with or at risk of HIV/AIDS who are in treatment for substance abuse (only required for FFY 2013 designated states)

TB—Persons with or at risk of TB who are in treatment for substance abuse

Additionally, a state may select “Other” for one or more additional populations (related to an unmet need or critical gap). Several other populations will appear. Check one of the boxes, or check “Other” again, and specify the population.

4) Describe the Goal of the Priority Area, a general characterization of what the state plans to accomplish.

5) Identify the state’s Strategies to Attain the Goal, meaning the step(s) the state will take to meet the goal.

6) In the Annual Performance Indicators section, provide the specific information that the state will use to determine at a future time whether or not the intended change has occurred. For the SABG, each indicator must reflect progress on a measure that is impacted by the Block Grant. For each performance indicator, specify the following components:

(a) A baseline measurement - Example: 100 substance using pregnant women successfully completed treatment in SFY 2012.

(b) A first-year target/outcome measurement (Achievement by end of SFY 2014). For most states, this is 06/30/2014. [For Alabama and Michigan it is 10/31/2014. For New York it is 03/31/2014. For Texas it is 09/30/2014. For Pennsylvania it is 06/30/2014, even though this is the end of its SFY 2013.] Example: 105 substance using pregnant women will have successfully completed treatment in SFY 2014.

(c) A second-year target/outcome measurement (Achievement by end of SFY 2015) For most states, this is 06/30/2015. [For Alabama and Michigan it is 10/31/2015. For New York it is 03/31/2015. For Texas it is 09/30/2015. For Pennsylvania it is 06/30/2015, even though this is the end of its SFY 2014.] Example: 110 substance using pregnant women will have successfully completed treatment in SFY 2015.

(d) Data source - Example: Client specific discharge data reported from the state’s WITS system.

(e) Description of data - Example: Discharge item #5 indicates whether the client was pregnant at discharge or gave birth while in treatment. Discharge item #20 identifies whether each client has

completed at least 50% of the goals identified in her treatment plan. Discharge item #25 indicates whether the client completed treatment (as opposed to leaving prior to a planned discharge).

(f) Data issues/potential caveats that affect outcome measures - Example: No issues are currently foreseen that will affect the outcome measures.

A state is accountable for meeting the goals and performance targets established in its plan, and will report on progress/achievement in the future SABG Reports that apply to this planning period (due December 1, 2014 and December 1, 2015).

Plan Table 1 - #1

1. Priority Area: Health Disparities	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): Other	
4. Goal of the priority area: Increase the number of individuals participating in substance abuse treatment who receive a physical examination and/or detailed medical history	
5. Strategies to attain the goal: Promotion of the utilization of E&M codes	
6. Annual Performance Indicators to Measure Goal Success: Indicator #1: Number of individuals participating in substance abuse treatment who receive a medical/physical evaluation	
a) Baseline measurement (initial data collected prior to and during SFY 2014): During FY11-12, a total of 340 individuals received a physical examination as part of their behavioral health assessment under codes 99201, 99202, 99203 or 99204.	
b) First-year target/outcome measurement (progress to end of SFY 2014): The number of individuals receiving care under an E&M code while in substance abuse treatment will increase by 1%.	
c) Second-year target/outcome measurement (final to end of SFY 2015): The number of individuals receiving care under an E&M code while in substance abuse treatment will increase by an additional 2%.	
d) Data source: CDW and paid claims	
e) Description of data: Client data warehouse information and paid claims	
f) Data issues/caveats that affect outcome measures: North Carolina is transitioning to a new multi-payer system that will process health care claims for approximately 70,000 enrolled DHHS providers who serve over one million North Carolina citizens.	

Plan Table 1 - #2

1. Priority Area: HIV	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): HIV/EIS	
4. Goal of the priority area: To increase the number of individuals tested for HIV while participating in a substance abuse treatment service	
5. Strategies to attain the goal: (a) Continue to provide HIV set aside funding to participating LMEs, contract agencies and the Division of Public Health in high risk and greatest need areas. (b) Continue to support services that include appropriate pretest counseling for HIV and AIDS, testing individuals with respect to such disease, appropriate posttest counseling, and providing appropriate therapeutic measures as a part of the recovery. (c) Monitor to assess clinically and fiscally the HIV service provision and provide technical assistance as needed at program sites	
6. Annual Performance Indicators to Measure Goal Success: Indicator #1: The number of persons enrolled in substance abuse treatment who receive HIV Early Intervention Services.	
(a) Baseline measurement (initial data collected prior to and during SFY 2014): Approximately 7300 individuals were tested in fy 11-12	
(b) First-year target/outcome measurement (progress to end of SFY 2014): Number tested will increase by 1%	
(c) Second-year target/outcome measurement (final to end of SFY 2015): Number tested will increase by an additional 2%	
(d) Data source: Semi-Annual Block Grant Compliance reports, reports from the Division of Public Health	
(e) Description of data: Semi-Annual Compliance reports are received from each LME/MCO and indicate how many people were tested, as well as how many received pre- and/or post-test counseling. This data is also collected by agencies with whom the Division of Public Health contracts and provided to DMH/DD/SAS on a semi-annual basis as well.	
(f) Data issues/caveats that affect outcome measures: None anticipated	

Plan Table 1 - #3

1. Priority Area: IV Drug Users	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): IVDUs and non-injecting opioid drug users	
4. Goal of the priority area: To reduce the number of deaths of state/federally funded individuals participating in opioid treatment programs (OTPs)	
5. Strategies to attain the goal: (a) Monthly meetings with OTP medical directors and quarterly meetings with OTP program directors to review protocols and best practice approaches for the provision of medication assisted therapies (b) Technical assistance and monitoring	
6. Annual Performance Indicators to Measure Goal Success: Indicator #1: Decreased number of deaths of individuals served in the OTPs that receive public funding.	
(a) Baseline measurement (initial data collected prior to and during SFY 2014): 25 deaths were reported by the 18 state and federally funded OTPs during FY 11-12, from an unduplicated count of 11,106 consumers, as per NCTOPPS initial assessments and updates	
(b) First-year target/outcome measurement (progress to end of SFY 2014): Deaths will be reduced by 2.5%	
(c) Second-year target/outcome measurement (final to end of SFY 2015): Deaths will be reduced by an additional 2.5%	
(d) Data source: NCTOPPS, IRIS	
(e) Description of data: NCTOPPS data will provide the number of individuals served in OTPs, as well as the phase of service each is participating in (induction, stabilization or taper). Deaths are reported through the IRIS system.	
(f) Data issues/caveats that affect outcome measures: Data will be collected from two different sources and will go through a "manual" matching process. On rare occasions, there is a delay in the reporting of a death because the treatment provider was unaware a death occurred.	

Plan Table 1 - #4

1. Priority Area: To ensure access to community based services for individuals involved in the justice system	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): Youth and adults involved in the juvenile and criminal justice systems	
4. Goal of the priority area: Maintain the current level of access for addressing the needs of people with substance use disorders involved with the criminal and juvenile justice systems.	
5. Strategies to attain the goal: Collaborate with the Divisions of Juvenile Justice and Adult Correction in the Department of Public Safety to maximize the use of resources for justice involved people with substance use problems.	
6. Annual Performance Indicators to Measure Goal Success: Indicator #1: Numbers of youth and adults involved with the justice systems who are served in the community	
(a) Baseline measurement (initial data collected prior to and during SFY 2014): 16,031 adults involved with the justice system were served in the community by TASC in SFY 2011-2012; 3256 youth involved with the justice system were served in the community through Juvenile Justice Partnerships in SFY 2011-2012	
(b) First-year target/outcome measurement (progress to end of SFY 2014): 16,000 adults involved with the justice system will be served in the community by TASC (end of SFY 2014); 3200 youth involved with the justice system will be served in the community through Juvenile Justice Partnerships (end of SFY 2014)	
(c) Second-year target/outcome measurement (final to end of SFY 2015): 16,000 adults involved with the justice system will be served in the community by TASC (end of SFY 2014); 3200 youth involved with the justice system will be served in the community through Juvenile Justice Partnerships (end of SFY 2015)	
(d) Data source: NC-TOPPS	
(e) Description of data: Individual outcome and Program performance data submitted by providers on behalf of consumers of substance abuse services in North Carolina's public service system.	
(f) Data issues/caveats that affect outcome measures: The SSA is currently transitioning as a Local Management Entity to include Managed Care Organization functions which will result in changes to the provider networks serving these consumers	

Plan Table 1 - #5

1. Priority Area: Community Integration	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): Individuals with substance use disorders (SUDs) experiencing homelessness or inadequate housing.	
4. Goal of the priority area: To increase the number of individuals with substance use disorders who access Oxford Houses.	
5. Strategies to attain the goal: <ul style="list-style-type: none"> • The Division will continue to provide no less than current level of funding to Oxford House, Inc. to support additional staff to increase outreach efforts and the number of Oxford House beds. • The Division upon receipt will forward Attestation documents to LME/MCO of newly opened Oxford Houses within their catchment area. • Contractor will serve at least 20 individuals coming out of incarceration • Contractor will assure that LME/MCOs are aware of newly opened Oxford Houses by Oxford House staff alerting LME/MCO of their plans to open Oxford Houses in their catchment area. 	
6. Annual Performance Indicators to Measure Goal Success: <p>Indicator #1: Number of NC Oxford House, Inc. beds available that are integrated in the community to serve adults with substance use disorders. Increased beds will be available to men, women and women with children.</p>	
(a) Baseline measurement (initial data collected prior to and during SFY 2014): 1,115 total beds available to adults with substance use disorders integrated in the community SFY 2011-2012	
(b) First-year target/outcome measurement (progress to end of SFY 2014): No less than 1,179 beds will be available to adults with substance use disorders integrated in the community.	
(c) Second-year target/outcome measurement (final to end of SFY 2015): No less than 1,249 beds will be available to adults with substance use disorders integrated in the community.	
(d) Data source: Oxford Houses: House Activity Report (Monthly) and Attestation Reports (completed on newly opened Oxford Houses)	
(e) Description of data: Information on location of Oxford Houses; relapse rate, and status of beds	
(f) Data issues/caveats that affect outcome measures: On occasion, an Oxford House may have to close, or be moved to a different location for various reasons.	

Plan Table 1 - #6

1. Priority Area: Access to quality treatment for pregnant women and women of childbearing age who are opioid dependent	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): PWWDC	
4. Goal of the priority area: Increase the number of pregnant women and women of childbearing age who have entered treatment for opioid dependence	
5. Strategies to attain the goal: (a) Creating and sustaining a statewide multidisciplinary stakeholder's workgroup to address the facets of barriers in accessing treatment and care for women and their infants. (b) Development of educational materials for multiple disciplines of professionals and women of child-bearing age, regarding opioids, pregnancy, medication assisted treatment and women's gender responsive treatment. (c) Dissemination of educational materials, training and technical assistance.	
6. Annual Performance Indicators to Measure Goal Success: Indicator #1: Number of pregnant women and women of childbearing age participating in an opioid treatment program	
a) Baseline measurement (initial data collected prior to and during SFY 2014): During FY11-12, 196 pregnant women between the ages of 18-45, who were currently involved in opioid treatment, reported use of heroin, other opiates/opioids, non-prescription methadone and Oxycodone in the past month or past year.	
b) First-year target/outcome measurement (progress to end of SFY 2014): Increase by 1% the number of pregnant women/women of childbearing age involved in opioid treatment	
c) Second-year target/outcome measurement (final to end of SFY 2015): Increase by an additional 1% the number of pregnant women/women of childbearing age involved in opioid treatment	
d) Data source: NCTOPPS	
e) Description of data: Individual outcome and program performance data submitted by providers on behalf of consumers of substance abuse services in North Carolina's public service system.	
f) Data issues/caveats that affect outcome measures: None anticipated	

Plan Table 1 - #7

1. Priority Area: Increase access to gender responsive, family-centered substance abuse services for pregnant women and women with dependent children.	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): PWWDC	
4. Goal of the priority area: Increase the number of pregnant women and women with dependent children who are referred to treatment for substance use disorders.	
<p>5. Strategies to attain the goal:</p> <ul style="list-style-type: none"> a. Maintain a dedicated Perinatal Substance Use Specialist position to ensure pregnant and parenting women receive appropriate screening and referrals for behavioral health and prenatal care and have access to up-to-date information regarding bed availability statewide, as applicable. b. Maintain and update a statewide capacity management database to identify available treatment slots in the perinatal, maternal and CASAWORKS programs statewide. c. Increase awareness of substance use issues and available resources relative to pregnant and parenting women with substance use disorders. 	
<p>6. Annual Performance Indicators to Measure Goal Success:</p> <p>Indicator #1: Number of pregnant women and/or women with dependent children who access gender-responsive substance abuse treatment services</p>	
(a) Baseline measurement (initial data collected prior to and during SFY 2014): 219 individuals received referrals to treatment in SFY 2011/2012	
(b) First-year target/outcome measurement (progress to end of SFY 2014): Increase by 1% the number of treatment referrals	
(c) Second-year target/outcome measurement (final to end of SFY 2015): Increase by an additional 1% the number of treatment referrals	
(d) Data source: Annual Perinatal Substance Use Project report	
(e) Description of data: The annual Perinatal Substance Use Project Report includes the number of individuals who call for treatment resources throughout the state for pregnant women and women with dependent children.	
(f) Data issues/caveats that affect outcome measures: None anticipated	

Plan Table 1 - #8

1. Priority Area: Increase access to substance abuse treatment services for military personnel, veterans and their families.	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): Other	
4. Goal of the priority area: The number of veterans with a substance use disorder who are referred to treatment will increase.	
5. Strategies to attain the goal: <ul style="list-style-type: none"> a. Maintain a dedicated Veterans Specialist position at each LME/MCO to increase community awareness of the availability of services and better assure accessibility to those services. b. Provide technical assistance to LME/MCOs, provider agencies and other organizations as needed. 	
6. Annual Performance Indicators to Measure Goal Success: <p>Indicator #1: Number of military personnel and/or veterans who access substance abuse treatment services</p>	
(a) Baseline measurement (initial data collected prior to and during SFY 2014): 1752 veterans received one or more episodes of treatment services during SFY 12	
(b) First-year target/outcome measurement (progress to end of SFY 2014): Increase by 1% the number of treatment referrals	
(c) Second-year target/outcome measurement (final to end of SFY 2015): Increase by an additional 1% the number of treatment referrals	
(d) Data source: CDW and paid claims	
(e) Description of data: Client data warehouse information and paid claims	
(f) Data issues/caveats that affect outcome measures: North Carolina is transitioning to a new multi-payer system that will process health care claims for approximately 70,000 enrolled DHHS providers who serve over one million North Carolina citizens.	

Plan Table 1 - #9

1. Priority Area: Early identification of individuals applying for public assistance who may be experiencing substance use problems that act as a barrier to self-sufficiency.	2. Priority Type (SAP, SAT): SAT
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): PWWDC, Other	
4. Goal of the priority area: In partnership with the Division of Social Services in all 100 NC counties, increasing the number of individuals identified who are in need of substance abuse treatment.	
5. Strategies to attain the goal: Maintain Qualified Substance Abuse Professionals in all 100 NC counties to perform substance abuse assessments with identified public assistance applicants.	
6. Annual Performance Indicators to Measure Goal Success: Indicator #1: Number of individuals screened for substance use disorders when applying for public assistance	
a) Baseline measurement (initial data collected prior to and during SFY 2014): 7282 individuals were assessed during FY11-12	
b) First-year target/outcome measurement (progress to end of SFY 2014): Increase the number of individuals served by 1%	
c) Second-year target/outcome measurement (final to end of SFY 2015): Increase the number of individuals served by an additional 1%	
d) Data source: The Quarterly Project Report of Work First/Child Protective Services Substance Abuse Initiative completed by statewide Local Management Entities/Managed Care Organizations, submitted to NC Division of Mental Health and Developmental Disabilities and Substance Abuse Services.	
e) Description of data: Number of individuals assessed based on quarterly reports completed by statewide Local Management Entities/Managed Care Organizations.	
f) Data issues/caveats that affect outcome measures: The NC General Assembly approved during this past legislative session a bill that will require urine drug testing for individuals applying for Work First benefits, for "whom the Department reasonably suspects is engaged in the illegal use of controlled substances." It is unknown at this time if this bill will have an effect on the number of individuals who apply for/participate in the Work First program.	

Plan Table 1 - #10

1. Priority Area: Substance Abuse Prevention	2. Priority Type (SAP, SAT): SAP
3. Populations (PWWDC, IVDUs, HIV/EIS, TB, Other): Other: At Risk/ High Risk Youth and their Families	
4. Goal of the priority area: To increase the number of youth who are alcohol, tobacco and drug free.	
5. Strategies to attain the goal: Utilize evidence based practices, activities, programs and policies to provide substance abuse prevention information, education.	
6. Annual Performance Indicators to Measure Goal Success:	
a) Indicator #1: The number of youth and their families enrolled in substance abuse prevention activities and programs.	
b) Baseline measurement (initial data collected prior to and during SFY 2014): Over 75,000 youth and their families received substance abuse information and education via one of the six strategies including information dissemination, education, problem identification and referral, alternatives, community based process and environmental during SFY 12.	
c) First-year target/outcome measurement (progress to end of SFY 2014): The number of individuals receiving substance abuse prevention programs and activities will increase by 2%.	
d) Second-year target/outcome measurement (final to end of SFY 2015): The number of individuals receiving substance abuse prevention programs and activities will increase by an additional 3%.	
e) Data source: Semi-Annual Block Grant Compliance reports	
f) Description of data: Semi-Annual Compliance reports are received from each LME/MCO and indicate how many individuals were enrolled in substance abuse prevention activities.	
g) Data issues/caveats that affect outcome measures: None anticipated:	

Use of Block Grant Dollars for Block Grant Activities

Table 2 – State Agency Planned Expenditures

Plan Table 2 State Agency Planned Expenditures							
(Include only funds expended by the Executive branch agency administering the SABG and/or MHBG)							
State Identifier: NC			Planning Period From: 07.01.13 to 06.30.15				
Activity	SABG	MHBG	Medicaid (Federal, State & Local)	Other Federal Funds (e.g., ACF, TANF, CDC, CMS, Medicare, SAMHSA, etc.)	State Funds	Local Funds (excluding local Medicaid)	Other
1.Substance Abuse Prevention & Treatment*							
(a) Pregnant Women & Women with Dependent Children*	\$7,598,158		\$4,384,489		\$3,261,910		
(b) All Other	\$19,936,126		\$4,182,097	\$593,091	\$115,508,792		
2.Primary Prevention**	\$7,823,543			\$618,071	\$400,000		
3.Tuberculosis	\$1,350,000						
4.HIV Early Intervention Services	\$1,955,886						
5. State Hospital							
6. Other 24-Hour Care							
7. Ambulatory/Community Non-24-Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$454,000						
11. Total	\$39,117,713		\$8,566,586	\$1,211,162	\$119,170,702	0	0

* Prevention other than primary prevention

** States may only use MH Block Grant funds to provide primary prevention services to the priority populations of adults with serious mental illness and children with serious emotional disturbance.

Table 3 – State Agency Block Grant Expenditures by Service (Unduplicated Individuals, Units and Expenditures)

Planning Period - From 07.01.2013 to SFY 06.30.2015

SERVICE	UNDUPLICATED INDIVIDUALS	UNITS	EXPENDITURES
Healthcare Home/Physical Health			\$132,594
General and specialized outpatient medical services (used E&M codes 99215, 99241 through 99245 here)	1577	1772	132,594
Acute Primary care			
General Health Screens, Tests and Immunizations			
Comprehensive Care Management			
Care coordination and Health Promotion			
Comprehensive Transitional Care			
Individual and Family Support			
Referral to Community Services Dissemination			
Prevention (including Promotion)			
Screening, Brief Intervention and Referral to Treatment			
Brief Motivational Interviews			
Screening and Brief Intervention for Tobacco Cessation			
Parent Training			
Facilitated Referrals			
Relapse Prevention/Wellness Recovery Support			
Warm Line			
Substance Abuse (Primary Prevention)			\$7,823,543
Classroom and/or small group sessions (Education)	19,992		890,000
Media campaigns (Information Dissemination)	15,778		150,000
Systematic Planning/Coalition and Community Team Building (Community Based Process)	10,352		533,750
Parenting and family management (Education)	3,335		798,093
Education programs for youth groups (Education)	50,000		3,655,000
Community service activities (Alternatives)	2,150		369,950
Student assistance programs (Problem Identification and Referral)	3000		523,500
Employee assistance programs (Problem Identification and Referral)	0		0

Community Team Building (Community Based Process)	1,302		308,250
Promoting the establishment or review of alcohol, tobacco and drug use policies (Environmental)	2,323		595,000
Engagement Services			\$417,352
Assessment	5426	15336	417,209
Specialized Evaluations (Psychological and Neurological)	2	2	143
Service Planning (including crisis planning)			
Consumer/Family Education			
Outreach			
Outpatient Services			\$1,179,924
Individual evidenced based therapies	2155	6749	222,001
Group Therapy	6988	119,841	952,841
Family Therapy	39	76	5,082
Multi-family Therapy			
Consultation to Caregivers			
Medication Services			\$1,314,521
Medication Management	2217	2813	136,796
Pharmacotherapy (including MAT)	1131	70,885	1,177,725
Laboratory Services			
Community Support (Rehabilitative)			\$4,819,377
Parent/Caregiver Support			
Skill building (social, daily living, cognitive) (Community Support Team added here)	113	4512	65,424
Case Management	271	773	62,888
Behavior Management			
Supported Employment	2	252	638
Permanent Supported Housing			
Recovery Housing	1920	51,871	4,690,427
Therapeutic Mentoring			
Traditional Healing Services			
Recovery Supports *			*
Peer Support			
Recovery Support Coaching			
Recovery Support Center Services			
Supports for Self-Directed Care			
Other Supports (Habilitative)			0
Personal Care			
Homemaker			
Respite			
Supported Education			

Transportation			
Assisted Living Services			
Recreational Services			
Trained Behavioral health Interpreters			
Interactive Communication Technology Devices			
Intensive Support Services			\$3,509,517
Substance Abuse Intensive Outpatient (IOP)	2718	34,556	3,215,756
Partial Hospital			
Assertive Community Treatment			
Intensive home based services	29	416	107,928
Multi-systemic Therapy	33	5080	185,833
Intensive Case Management			
Out-of-Home Residential Services			\$1,607,554
Crisis Residential/Stabilization	1335	62,573	1,200,798
Clinically Managed 24-Hour Care (SA) (used non-hospital med detox)	297	1036	341,389
Clinically Managed Medium Intensity Care (SA) (used social setting detox)	397	1084	128,367
Adult Mental Health Residential			
Youth Substance Abuse Residential Services			
Children's Mental Health Residential Services			
Therapeutic Foster Care			
Acute Intensive Services			\$700,693
Mobile Crisis Services	986	8656	293,070
Peer Based Crisis Services			
Urgent Care Services			
23 Hour Crisis Stabilization Services			
Medically Monitored Intensive Inpatient (SA) (used E&M codes 99221 thru 99254 here)	792	1256	407,623
24/7 Crisis Hotline Services			
Other			
TOTAL			\$21,505,075

*This table primarily contains services that are funded through a fee-for-service model, with the exception of the Primary Prevention section. It should be noted that North Carolina also purchases services through expenditure-based contracts. Contracts of this type are utilized when the services desired are not covered under the current State Plan Amendment or needs are better met through a different funding methodology. An example of this is Recovery Support Coaching – this service is being implemented in several regions of the state as part of the Recovery Oriented System of Care, but because our current service definitions do not contain this service, these initiatives are funded through grants.

Table 4 – SABG Planned Expenditures

Plan Table 4		
SABG Planned Expenditures		
State Identifier: NC		Planning Period: From 10.01.13 to 09.30.15
Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1. Substance Abuse Prevention* & Treatment	\$27,534,284	
2. Primary Prevention	\$7,823,543	
3. HIV Early Intervention Services**	\$1,955,886	
4. Tuberculosis Services	\$1,350,000	
5. Administration (SSA level only)	\$454,000	
6. Mental Health Primary Prevention	0	
7. Mental Health Evidence-based Prevention and Treatment (5% of total award)	0	
8. Total	\$39,117,713	

* Prevention other than primary prevention

** HIV designated states only

Table 5a – SABG Primary Prevention Planned Expenditures (detailed)

Planning Period from SFY 2014 to SFY 2015

Strategy	IOM Target	FY 2014	FY2015
Information Dissemination	Universal	\$720,000	
	Selective	\$238,587	
	Indicated	\$165,000	
	Unspecified	\$0	
	Total	\$1,123,587	
Education	Universal	\$890,000	
	Selective	\$1,415,000	
	Indicated	\$1,240,000	
	Unspecified	\$0	
	Total	\$3,545,000	
Alternatives	Universal	\$145,750	
	Selective	\$224,200	
	Indicated	\$198,050	
	Unspecified	\$0	
	Total	\$568,000	
Problem Identification and Referral	Universal	\$179,500	
	Selective	\$278,200	
	Indicated	\$245,300	
	Unspecified	\$0	
	Total	\$703,000	
Community Based	Universal	\$208,750	

Process	Selective	\$325,000	
	Indicated	\$286,250	
	Unspecified	\$0	
	Total	\$820,000	
Environmental	Universal	\$152,500	
	Selective	\$235,000	
	Indicated	\$207,500	
	Unspecified	\$0	
	Total	\$595,000	
Section 1926 Tobacco	Universal	\$191,400	
	Selective	\$138,778	
	Indicated	\$138,778	
	Unspecified	\$0	
	Total	\$468,956	
Other	Universal	0	
	Selective	0	
	Indicated	0	
	Unspecified	0	
	Total	0	
Total Prevention Expenditures		\$7,823,543	
Total SABG Award		\$39,117,713	
Planned Primary Prevention %		20%	

Table 5b - SABG Primary Prevention Planned Expenditures (from Table 5a)

State Identifier: NC		
Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$975,726.31	
Universal Indirect	\$1,218,626.49	
Selective	\$3,002,234.80	
Indicated	\$2,626,955.40	
Column Total	\$7,832,543	
Total SABG Award	\$39,117,713	
Planned Primary Prevention Percentage	20%	

Table 5c – Planned Primary Prevention Targeted Priorities

Targeted Substances	
1. Alcohol	6. Heroin
2. Tobacco	7. Inhalants
3. Marijuana	8. Methamphetamines
4. Prescription Drugs	9. Synthetic Drugs (i.e., bath salts, Spice, K2)
5. Cocaine	
Targeted Populations	
1. Students in college	7. Homeless
2. Military Families	8. Native Hawaiians
3. LGBTQ	9. Asians
4. American Indian/Alaska Natives	10. Rural
5. African Americans	11. Underserved Racial & Ethnic Minorities
6. Hispanics	

Footnote: The Prevention and Early Intervention Team has chosen to focus on all substances and populations for application period. If it is determined via needs assessment or other data informed sources that there is a need to focus on a specific substance or target population, we will do so at that time.

Table 6a – SABG Resource Development Activities Planned Expenditures

Plan Table 6A					SABG Resource Development Activities			
State Identifier: NC					Planning Period: From 10.01.13 to 09.30.15			
	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1.Planning, Coordination & Needs Assessment	74,170	267,452		\$341,622				
2. Quality Assurance								
3. Training (Post-employment)	268,435	178,870		\$447,305				
4. Education (Pre-employment)	546,767	476,478		\$1,023,245				
5. Program Development		431,761		\$431,761				
6. Research & Evaluation	460,869	886,296		\$1,347,165				
7. Information Systems								
8. Enrollment and Provider Business Practices (3% of BG award)		*						
9. Total	\$1,350,241	\$2,240,857		\$3,591,098				

* The Division currently contracts with the Governor's Institute on Substance Abuse and the Behavioral Healthcare Resource Program, UNC School of Social Work, to provide training to providers on enrollment and successful business practices, but our current contract language does not distinguish an amount of funding specifically for these activities. We will amend those contracts, include specific language and a specific amount of funds for such next fiscal year.

Narrative Plan

C. Coverage M/SUD Services

Narrative Question: Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

1. *Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?*

At this date, North Carolina has decided not to expand Medicaid coverage for adults, in part due to current challenges related to the management of the Medicaid budget. The state has also decided that it will not set up a health insurance exchange, but will offer plans through the federal exchange. Block grant and state dollars will therefore continue to be used for people who are uninsured. These funds will also be used to pay for services that are not covered by insurance and Medicaid. Screening and brief interventions for alcohol and drug misuse are currently covered if provided by physicians and other medical practitioners in primary care clinics.

2. *Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?*

DMH/DD/SAS has a system for monitoring access to mental health and substance use services that is based on payments made by state, Medicaid and other federal sources of funding for appropriate services. The Division also plans to expand its role to monitor QHPs in the exchange, including access to care, actual benefit plans and adherence to parity requirements.

3. *Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.*

Currently, the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services are jointly responsible for monitoring the Local Management Entities/Managed Care Organizations. Each LME/MCO submits data to DMH/DD/SAS on a quarterly basis that measures timely access to services, based on the urgency of the need (emergent, urgent or routine). Any future plans that will be offered through the federal exchange will be monitored by DMH/DD/SAS.

4. *Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?*

As North Carolina will offer plans through the federal exchange, the Division will work with the federal government to ensure that we have a role in reviewing complaints.

5. *What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?*

The essential health benefit is a basic benefit; therefore North Carolina will continue to pay for services not covered that are believed to be essential to the overall stabilization and recovery of individuals, such as recovery support services.

D. Health Insurance Marketplace

Narrative Question: Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities. Please answer the following questions:

1. *How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?*

The state is developing a system known as North Carolina Families Accessing Services through Technology (NC FAST) to be implemented in 2013, for electronic application, eligibility and enrollment into the Medicaid and Children's Health Insurance Program (CHIP). NC FAST will also be the system for determining eligibility and applying for coverage through the federal health benefit exchange, in which NC will be participating. NC FAST will allow the state to evaluate the impact of its outreach, eligibility determination, enrollment and re-enrollment systems on eligible individuals with behavioral health conditions. NCFast will also determine eligibility for state and federal block grant funds. NC FAST originates in the Division of Social Services, with whom DMH/DD/SAS is a partner, and a sister agency under the DHHS umbrella.

2. *How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?*

North Carolina is working with Enroll America to educate individuals regarding their eligibility for services. At this time, the state is seeking partnerships with the LME/MCOs and others to solicit Navigators and educate potential consumers. The Division has encouraged a number of substance abuse and mental health advocacy organizations to apply for funds to become navigators.

3. *How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?*

The North Carolina legislature requires that household income information be collected, as well as third party insurance information, and requires LME/MCOs to repay state and federal funds if contracted providers collect third party reimbursements after claims have been paid with state or federal funds. NC FAST will be used to verify income and third party insurance beginning in FY13-14.

4. *How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?*

North Carolina currently operates under a 1915 (b)/(c) waiver. LME/MCOs are responsible for ensuring an adequate array of quality providers of mental health and substance abuse services in their catchment areas. The state is exploring a Medicaid 1115 waiver to integrate behavioral and physical health care through the development of comprehensive care entities (CCEs). It is anticipated that three to four companies will be responsible for arranging coverage and care statewide. These will likely include private health insurance companies that will also be QHPs in the health benefit exchange. These CCEs will be responsible for the provision of Medicaid, state and federally funded behavioral health services. We will be assisting our current provider networks (LME/MCOs and behavioral health providers) to make this transition over the next two to three years.

5. *Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.*

A total of 29,933 individuals (29,424 adults and 509 children) with substance use disorders were served using either state funds or funds from the substance abuse block grant in state fiscal year 2012, based on the DMH/DD/SAS paid claims database. Approximately 8% of adults and 19% of adolescents may have also had Medicaid, but no coverage for the service or level of care indicated. The following table illustrates the methodology for deriving the percentage of individuals who received state or federally funded behavioral health services for a substance use disorder, who also had Medicaid.

Payor Source	Adults	Children & Youth
Medicaid	20,442	2,075
State and/or Federal	29,424	509
Total Served (Duplicated)	49,866	2,584
Total Served (Unduplicated)	47,424	2,488
Difference	2,442	96
% with Only State/Federal Funding	92%	81%

Although the funding for the substance abuse block grant will be slightly decreased in FY14, the state will attempt to cover the same number of individuals in CY 2013, as the decision not to expand Medicaid coverage has been made.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

It has been estimated by the North Carolina Institute of Medicine that approximately 90,000 individuals would have become Medicaid eligible if North Carolina had expanded coverage or participated in the Affordable Care Act. It is expected that the number of uninsured individuals will remain essentially the same in 2014 and 2015 given the state's decision not to expand Medicaid coverage. However, North Carolina's population has continued to grow; therefore, we could potentially see a slight increase in the number of uninsured individuals over the next two to three years.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

Approximately 108 providers were listed on Table 8 as contracted agencies for federally funded substance abuse prevention and treatment services during fiscal year 11. Of those 108, 60 are currently enrolled as Medicaid providers. The Division maintains a list of all Medicaid enrolled providers including group practices, licensed independent practitioners, medical doctors, comprehensive community agencies, etc. This list will be merged with the list of contracted providers periodically to monitor participation.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

DMH/DD/SAS has been working for approximately six years to prepare providers to function under a fee-for-service model. As most providers of state and federally funded services are also Medicaid providers, we do not anticipate a big change or decrease.

E. Program Integrity

Narrative Question: The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a -typical employer plan in that state as required by the Affordable Care Act.

At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

- 1. Does the state have a program integrity plan regarding the SABG and MHBG?*
- 2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?*
- 3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:*
 - a. Budget review;*
 - b. Claims/payment adjudication;*
 - c. Expenditure report analysis;*
 - d. Compliance reviews;*
 - e. Encounter/utilization/performance analysis; and*
 - f. Audits.*
- 4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?*
- 5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?*
- 6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?*

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Please see the attached Service System Integrity Plan for the Division of MH/DD/SA Services (located at the end of this document).

F. Use of Evidence in Purchasing Decisions

Narrative Question: SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?*

Staff from each section in the Division are assigned to the North Carolina Practice Improvement Collaborative (NC PIC) to review evidence-based or promising practices and assess applicability to the system of care in North Carolina, including implementation methodology. (See question 3 below for more information on NC PIC). In addition, one of the teams within the Community Policy Management section, the Best Practices Team, works directly with LME/MCOs, providers and other state agencies to research, revise and implement evidence-based practices. For example, the Assertive Community Treatment and Supported Employment service definitions were recently revised to align more closely with identified best practices. Reimbursement rates have been adjusted and trainings have been provided to LME/MCOs and providers to aid in the successful implementation of these services.

- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?*

a) What information did you use?

b) What information was most useful?

Yes, NC PIC and developers have selected practices from the National Registry of Evidence-based and Programs and Practices (NREPP) that have been incorporated into North Carolina's enhanced service definitions. Agencies who contract with LME/MCOs for the provision of these types of services must meet the requirements contained within the service definitions.

- 3) How have you used information regarding evidence-based practices?*

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

Through a contract with the Governor's Institute on Substance Abuse, in 2005 the Division developed the North Carolina Practice Improvement Collaborative (NC PIC) to provide guidance in determining which specific evidence based services and supports will be provided through the public system. The Chief of the Community Policy Management section within the Division of MH/DD/SAS was integral in the creation of this professional collaborative and continues to provide clinical guidance and leadership, as well as financial support. The mission of NC PIC is to ensure that each time any North

Carolinian—whether a child or an adult, a member of a majority or minority, from an urban or rural area—comes into contact with the DMH/DD/SAS system, that individual will receive excellent care that is consistent with our scientific understanding of what works (*New Freedom Commission on Mental Health, 2003*).

The NC PIC is comprised of representatives from all three disabilities, and meets quarterly to review and discuss relevant programs. Annually the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum, defined as the North Carolina Practice Improvement Congress, features brief educational descriptions of the practices being recommended by the NC PIC in its report. The work of the NC PIC is primarily achieved during quarterly subcommittee meetings. At each meeting, the members review and discuss applications that have been submitted for evaluation. In addition, NC PIC has been instrumental in providing information, trainings and webinars on specific topics or practices such as Trauma-Focused Cognitive Behavioral Therapy, Integrated Dual Disorders Treatment, Contingency Management, *“Comparison of Treatment Foster Care Models,” “From the War Zone to the Home Front,”* etc. **More information can be found at the following website:** <http://www.ncpic.net/>.

In June 2012, the Quality Management Team, within DMH/DD/SAS, released the results of its survey on evidence-based practices that was administered to all critical access behavioral health agencies (CABHAs – similar to comprehensive community behavioral health centers). The survey’s objectives were to identify the evidence-based practices utilized by CABHAs and obtain information on how CABHAs monitored fidelity to those evidence-based practices. Of the CABHAs that responded, Motivational Interviewing was the most common evidence-based practice utilized, followed by Relapse Prevention, Dialectical Behavior Therapy, the Matrix Model and Integrated Dual Disorders Treatment. LME/MCOs, as per their Performance Agreement with DMH/DD/SAS, are required to “endeavor to ensure consumers have a choice of evidence based practices and treatments.”

G. Quality

Narrative Question: Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	<i>Prevention</i>	<i>Substance Abuse Treatment</i>	<i>Mental Health Services</i>
<i>Health</i>	<i>Youth and Adult Heavy Alcohol Use - Past 30 Day</i>	<i>Reduction/No Change in substance use past 30 days</i>	<i>Level of Functioning</i>
<i>Home</i>	<i>Parental Disapproval Of Drug Use</i>	<i>Stability in Housing</i>	<i>Stability in Housing</i>
<i>Community</i>	<i>Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval</i>	<i>Involvement in Self-Help</i>	<i>Improvement/Increase in quality/number of supportive relationships among SMI population</i>
<i>Purpose</i>	<i>Pro-Social Connections – Community Connections</i>	<i>Percent in TX employed, in school, etc - TEDS</i>	<i>Clients w/ SMI or SED who are employed, or in school</i>

- 1) *What additional measures will your state focus on in developing your State BG Plan (up to three)?*
- 2) *Please provide information on any additional measures identified outside of the core measures and state barometer.*
- 3) *What are your states' specific priority areas to address the issues identified by the data?*

Please see the priority areas identified in Steps 3 and 4, tables one through 10, priority areas and annual performance indicators.

- 4) *What are the milestones and plans for addressing each of your priority areas?*

The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services' Quality Management principles work to ensure continual improvement initiatives are customer focused, strategic and communicated with all stakeholders. The Division's Quality Management process tracks and uses programmatic data and stakeholder input for Executive Leadership Team decision making.

Quality management is a function of all Division employees and is incorporated in the organization's structure, the scope of activities, individual performance responsibilities and mechanisms for ensuring that the aims of the service system are communicated and monitored for achievement. Throughout all Division sections, critical outcomes and performance measures are identified and tracked to ensure the effectiveness of the service system.

DMH/DD/SAS has a Quality Management Team that was established with the reorganization of DMH/DD/SAS in 2003 when evaluators and researchers were brought together from various branches within the Division to create a framework for the evaluation of the service delivery system, determine performance measures and systematize data collection and reporting, among other functions. Since then, the QM Team has participated in the development of the DMH/DD/SAS Client Data Warehouse (CDW), refined the collection of National Outcomes Measures (NOMs) for the Substance Abuse Prevention and Treatment Block Grant through a series of data infrastructure grants, expanded the NC Treatment and Outcomes Program Performance System (NC TOPPS) and implemented a web-based substance abuse prevention data collection tool under a contract with Knowledge-based Information Technology Solutions (KIT Solutions). The QM Team disseminates reports directly to the DMH/DD/SAS

Quality Management Steering Committee to aid in the decision making process at its monthly meetings. Data is shared with stakeholders through the DMH/DD/SAS website to show system performance on various measures, including the NOMS, at the state, LME/MCO and county level quarterly, annually or in real time with its dashboard measures. The Data Operations Team and the QM Team are also responsible for the reporting of indicators required by the Substance Abuse Prevention and Treatment Block Grant. The QM Team currently has nine members on its staff. All have advanced graduate degrees; five have doctorates with publications in peer-reviewed journals.

In an effort to address our state's challenges and strengthen our ability to work collaboratively across departments, North Carolina's Department of Health and Human Services (DHHS) has initiated a quality improvement program, *DHHS Excels*, which brings together the work of all divisions within the department under five goals. The goals are intended to provide information to set priorities, measure progress, strengthen accountability and identify opportunities for efficiency and collaboration. Our ability to achieve person-centered outcomes and increased customer satisfaction will be achieved by: (1) monitoring infrastructure and resources, (2) public education and universal prevention, (3) targeted prevention, (4) treatment and services to help individuals stay in their home communities, and (5) treatment and services for those who need intensive (inpatient) services to help them return to their communities. These goals drive performance measurement for all of the DHHS divisions and are used to shape performance goals and measures for department staff, as well as LME/MCOs and providers of substance abuse services.

Our work builds on the Division's performance measurement work of the past decade and like any continuous quality improvement initiative, it evolves to meet the current needs of the service system. NC uses a combination of process, output and outcome measures, including NOMS, Washington Circle and HEDIS measures, to evaluate the quality of care and progress on state initiatives at the local and state level. Decision making at the Division level uses the performance data trends and patterns across the state to target training needs, service development and other initiatives to improve the service system.

Adherence to policies and procedures regarding adverse consumer events, complaints and grievances are outlined in administrative rules that tie response to local monitoring and investigation of providers. Response is expected to be initiated at the most immediate level, with development of prevention actions, successive look-behinds and back-up procedures in place to ensure appropriate actions are taken. The Division developed and implemented a statewide web-based Incident Response and Improvement System (IRIS) in SFY 2010 that is being used by LME/MCOs and sister agencies at the state level to ensure appropriate, timely response to critical incidents by providers, LME/MCOs and state oversight agencies. The system allows trending of information, which enables local and state partners to identify areas of concern and implement improvement initiatives.

The Division's Quality Management Steering Committee is charged with updating the Quality Management Plan (see Section R) and incorporating policies and procedures that cover areas of quality management into a consolidated document, using SAMHSA's initiatives and block grant expectations, the CMS Quality Framework, and 1915 b/c waiver requirements as resources. The plan incorporates: (1) assessment of needs, risks, and service gaps, (2) ensuring health and safety, (3) ensuring quality of care, (4) identification of and response to problems and complaints, (5) setting of strategic goals and

performance measures, (6) internal and system-wide improvement, and (7) evaluation of the quality management strategy. In an effort to be more effective and efficient, quality management principles are integrated into the workflow at all levels of the Division to promote quality, accountability and affordability.

H. Trauma

Narrative Question: In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Consumers of publicly-funded services enter the behavioral health system through Access and Referral Centers located in each LME/MCO. Each potential consumer is assessed for urgency and screened for the appropriate type of service and level of care; i.e., screening, triage and referral. The DMH/DD/SAS requires each Access Center to use a standardized screening form that includes questions on trauma history. In addition, the Division utilizes block grant funds to support a statewide Perinatal and Maternal Substance Abuse Initiative, as well as a CASAWORKS for Families Residential Initiative where evaluating for trauma is part of the screening and assessment process.

The Division's web-based data collection system, the NC Treatment and Outcomes Program Performance System (NC TOPPS), is required to be completed by providers for all consumers receiving publicly-funded substance abuse services. This measurement tool includes questions on trauma. In addition, the Division has worked with providers to assist them in obtaining training, clinical supervision and implementation of trauma-informed Cognitive Behavioral Therapy. For example, all eight of the residential facilities for adolescents with substance use have been trained in the UCLA PTSD Screening Index.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

The state currently does not have policies designed to connect individuals with trauma histories to trauma-focused therapy. However, NC DHHS, through DMH/DD/SAS, is submitting an application to SAMHSA for a System of Care (SOC) Expansion Planning Grant where trauma is a primary focus. DMH/DD/SAS is committed to addressing trauma whether the grant is funded or not, not only for children and youth but also for the entire system.

3. Does your state have any policies that promote the provision of trauma-informed care?

The state does not currently have any policies in place; however, the provision of trauma-informed care is highly promoted. In addition to utilization of the UCLA PTSD Screening Index, the GAIN, which has a robust section on victimization and trauma, has been implemented in all youth detention centers in North Carolina and is used by a significant number of outpatient providers. Seven Challenges, which is indicated for youth with co-occurring trauma, has been implemented with seven of the eight residential programs for youth and has significant utilization by the cadre of providers who serve adolescents with substance use disorders. Outpatient providers, as well as two adolescent residential programs, have received training in Seeking Safety.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

DMH/DD/SAS conducted a survey on evidence-based practices used by its providers between March and April 2012 and found Trauma Focused Cognitive Behavior Therapy as the second most common for children and youth diagnosed with mental health disorders. The second most common EBP was Seeking Safety.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Trainings are provided by Local Management Entities/Managed Care Organizations, the Area Health Education Centers (AHECs) and universities to increase the capacity of providers qualified to deliver trauma-specific interventions. The trainings include motivational interviewing in addition to the trauma-specific intervention and fidelity monitoring.

The Division has had a contract with the Center for Child and Family Health, national experts in child trauma treatment, for a number of years, to provide training across the state on trauma-informed care. In addition to the provision of direct care, the Center also maintains a list of all certified trauma-focused Cognitive Behavior Therapy (CBT) practitioners in North Carolina. Providers are encouraged to refer to certified practitioners if they do not have qualified staff within their agencies.

DMH/DD/SAS is also collaborating with the Division of Social Services to train the provider system statewide through a federal grant that focuses on identifying trauma in children and adolescents who are part of the public welfare system, and securing appropriate, quality treatment for that population.

I. Justice

Narrative Question: The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and

facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please answer the following questions:

- 1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?*

At this time, North Carolina has chosen not to expand Medicaid eligibility under the Medicaid expansion provided in the Affordable Care Act.

- 2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?*

- The North Carolina **Controlled Substances Reporting System (CSRS)** requires pharmacies to report all outpatient prescriptions dispensed for a controlled substance to a central database. Prescribers and dispensers access the database to identify harmful or excessive patterns of prescriptions to provide more effective and safer treatment for their patients. The purpose of the law is to increase the state's ability to identify controlled substance abusers or misusers and refer them for treatment and to help identify and stop the diversion of prescription drugs in an efficient and cost effective manner that will not impede the appropriate medical utilization of licit controlled substances.
- Throughout North Carolina, law enforcement, mental health professionals and advocates are joining in partnership to establish **Crisis Intervention Teams (CIT)**. CIT programs provide law enforcement the knowledge and skills they need to de-escalate persons in crisis and emphasize treatment rather than jail time for persons displaying symptoms of mental illness. The Division of MH/DD/SAS coordinates this statewide initiative through its Justice Systems Team.

- Persons charged with **Driving While Impaired (DWI)** may obtain an assessment from a network of more than 400 authorized substance abuse service provider agencies prior to their initial court appearance.
- **Drug Education Schools (DES)** are a diversion opportunity for first-time offenders per NC General Statute 90-96 in cooperation with District Attorneys' offices. The NC Justice Reinvestment Act of 2011 expanded eligibility criteria regarding felony charges in NC General Statute 90-96 and required that the option be made available to all first-time felony drug possession offenders. Previous law only allowed for felony possession of less than one gram of cocaine and it was at the prosecutor's discretion whether to defer prosecution on any drug offense. The Division of MH/DD/SAS coordinates this statewide initiative through its Justice Systems Team by ensuring the training and certification of DES Instructors.
- **Juvenile Justice Substance Abuse Mental Health Partnerships** serve youth on diversion contracts and those that are pre-adjudication (see description in #3).

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

- The NC Department of Health and Human Services entered into a Memorandum of Agreement with the Department of Correction (now Department of Public Safety) in 2000. The Administrative Office of the Courts joined the agreement in 2005. While the MOA continues to guide local operations, it is currently being updated to reflect new legislation and evidence based correctional practices.
- **Treatment Accountability for Safer Communities (TASC)** bridges justice and treatment systems by linking treatment and justice goals of reduced drug use and criminal activity. Objectively balancing public safety and public health, the TASC care management model reduces recidivism and improves justice, treatment and individual outcomes. TASC is organized into four regions which reflect the state's four judicial divisions, consistent with the unified court and statewide probation systems, and is available in all 100 North Carolina counties. Services include: screening and assessment of an offender's need for substance abuse or mental health services; treatment matching to ensure that the offender receives the correct level and type of care; referral and placement with appropriate service providers; and care management through individualized service planning, coordination and monitoring to ensure compliance with criminal justice conditions, progress in treatment and recovery supports. Through access to an array of services, TASC prepares probationers, parolees and post-releasees for a healthy and safe return to their communities.
- DMH/DD/SAS has a long-standing partnership with the Judicial Branch and the NC Division of Adult Correction in the development, implementation and on-going support of North Carolina's **Drug Treatment Courts**. DMH/DD/SAS was an original partner in the development of the program, serves as a legislatively mandated member of the State Advisory Committee and is a signatory to the State Memorandum of Agreement regarding the operation of Drug Treatment Courts. TASC provides the care management for most of the adult treatment courts.

- DMH/DD/SAS was involved in the work leading up to the **Justice Reinvestment Act of 2011**, and continues to be involved with its on-going implementation. The Act makes substantial changes to sentencing and corrections law in North Carolina - the most sweeping changes to NC's Structured Sentencing Act since its passage in 1994. The law requires the Department of Public Safety (DPS) "to develop the minimum program standards, policies and rules for community-based corrections programs and to consult with the Department of Health and Human Services on those standards, policies and rules that are applicable to licensed and credentialed substance abuse services" (143B-274.6.(a)(2)) and "to collaborate with the Department of Health and Human Services on focusing treatment resources on high-risk and moderate to high need offenders on probation, parole and post-release supervision" (143B-274.6.(a)(5)). In contracting for services, it requires DPS to "in partnership with the Department of Health and Human Services . . . develop standard service definitions and performance measures for substance abuse and aftercare support services . . ." (143B-274.7.(c)).

DMH/DD/SAS worked with the Division of Adult Correction, DPS, to define the priority offenders. While the divisions agree that all offenders under community-based supervision will be managed effectively, offenders who are high risk and moderate to high need are the priority. This includes Level 1, 2 and 3 offenders identified through the Division of Adult Correction's research-based risk and need assessment tools. DMH/DD/SAS assisted in the development of the Request for Proposals under the Act's Treatment for Effective Community Supervision Program which is intended to support the use of evidence-based practices to reduce recidivism and the rate of probation and post-release supervision revocations, as well as to promote coordination between state and community-based corrections programs. The Division of Adult Correction used existing state service definitions as the specifications for purchasing substance abuse treatment services.

- **Driving While Impaired (DWI) Services** are specialized services that ensure individuals with DWI convictions complete a clinical substance use assessment, and either substance abuse intervention or treatment before their license may be considered for reinstatement. The services offered include the following levels of care: ASAM Level .05 (early intervention), ASAM Level I (outpatient), ASAM Levels II.1 and II.5 (intensive outpatient and comprehensive outpatient) and various ASAM Level III services (residential and inpatient). DMH/DD/SAS administration of these services includes: policy development; technical assistance; training; oversight of DWI-related evidence-based practices, laws and rules; and authorization and monitoring of DWI-specific service providers. The DWI Services office coordinates with the Division of Motor Vehicles (DMV), NC Department of Transportation, to ensure substance abuse services are verified and communicated to DMV as required for DWI offenses and DWI-related Driving While License Revoked offenses. An automated process for directly entering information regarding treatment compliance into the individual's motor vehicle record at DMV is used.
- DMH/DD/SAS works collaboratively with Division of Juvenile Justice (DJJ), DPS central office staff, to manage the **Juvenile Justice Substance Abuse Mental Health Partnerships**. The Partnerships are local teams lead by LME/MCO and DJJ staff working together with providers to deliver effective, family-centered services and supports for juvenile justice-involved youth with substance use and/or

mental health problems. The Partnerships operate under System of Care principles and ensure the completion of comprehensive substance abuse and mental health assessments; the provision of evidence-based treatment options; the use of Child and Family Teams; and the involvement of DJJ's Juvenile Crime Prevention Councils to support a recovery-oriented system of care. Partnerships are active in 72 out of 100 counties and serve youth that have been adjudicated delinquent, adjudicated undisciplined or on diversion contracts and are pre-adjudication.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

- **Juvenile Justice Substance Abuse Mental Health Partnerships** emphasize checking eligibility for and enrolling eligible clients in programs, such as Medicaid and Health Choice, so that SABG and MHBG funds may be used to provide services, supports and other needs that have no other funding source.

Each LME/MCO leading a Juvenile Justice Substance Abuse Mental Health Partnership team has a contractual obligation to provide care coordination for people discharged from state facilities, community hospitals and emergency departments, detoxification services and crisis services. In addition, the LME/MCO representative on the local team is often a member of the Care Coordination section of that LME/MCO. Operating under System of Care principles and using Child and Family Teams, the Partnerships are particularly designed to address coordination of care, including transitioning youth from Detention and Youth Development Centers back to the community.

- While the majority of adult justice-involved offenders are not Medicaid eligible, the **Treatment Accountability for Safer Communities (TASC)** Standard Operating Procedures outline in the Placement Activities chapter the responsibilities for considering potential funding sources. TASC assists offenders in accessing services through authorization and coordination of services with the LME/MCO and treatment provider requirements. In an effort to maximize treatment resources, all available treatment programs are considered, including those funded by DPS.
- One of the purposes of the **Memorandum of Agreement** between DHHS, the Department of Correction (now Department of Public Safety) and the Administrative Office of the Courts is to create a seamless system built on the ideals of integrated service delivery and coordination of resources that provide effective interventions for offenders.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

- CIT trainings are conducted in all LME/MCOs in North Carolina. Since its inception, as of January 2012:
 - 3925 law enforcement officers are CIT certified
 - 280 law enforcement agencies have participated in CIT
 - 453 telecommunicators (dispatchers) have received CIT training

These results, when compared to results from 2010, indicate that an additional **893** CIT officers became CIT certified in calendar year 2011, resulting in an increase of **29%** from the previous year, and that an additional **38** law enforcement agencies began participating in a CIT program in North Carolina in 2011, representing a **16%** increase from the previous year in the number of law enforcement agencies participating in a CIT program. In addition, 2011 saw an additional **72** telecommunicators trained in CIT, a **19%** increase from the previous year.

- Fall and Spring Regional meetings are held with the local teams of the **Juvenile Justice Substance Abuse Mental Health Partnerships**. The regional meetings are held to model collaboration at the state level and encourage collaboration at the local level. Training offered through these meetings is determined by the local team's requests and needs and has included topics such as the role of Young Adult Advocates, Increasing Family Engagement, Creating an Effective System of Care for Juvenile Justice-Involved Youth and Care Coordination. Through this juvenile justice initiative, a variety of other trainings are provided to promote the use of evidence-based practices and treatments across the systems, such as the Global Appraisal of Individual Needs, Trauma-Informed Care, Seven Challenges and Brief Challenges.
- Through **TASC**, free online trainings are available to treatment providers and criminal justice professionals on topics such as Training for Community Corrections Officers on People with Cognitive Disabilities, Developing Responsive Systems for Substance Abusing Offenders, Integrating Substance Abuse Treatment and the Criminal Justice System and Patient Engagement. TASC also makes its webinars available to the Department of Public Safety's staff in their Community Corrections and Alcohol and Chemical Dependency Program sections. Recent webinars have included the NC Justice Reinvestment Act, Addiction and the Brain, Stress Management for Professionals, Client Empowerment and Community-Based Overdose Prevention. TASC staff present criminal justice-related topics at a variety of training events such as the NC Substance Abuse Professional Practice Board annual meetings and the Addiction Professionals of NC conferences.
- For **DWI** Services at the ASAM .05 level of care, Prime for Life, an evidence-based curriculum was adopted for individuals who are not diagnosed with a substance use disorder but have been convicted of a single DWI offense. DMH/DD/SAS trains providers in this curriculum. DMH/DD/SAS DWI Services staff provide training through a variety of existing training venues as well.

J. Parity Education

Narrative Question: SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. *How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?*

The Division has sponsored and conducted numerous trainings on parity. Recovery NC will also be providing training on parity and enrollment in QHPs.

2. *How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?*
3. *What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?*

Information has and will continue to be published on the Division's website and through consumer-focused publications. Information is also provided to the LME/MCOs, to then be disseminated to their provider networks. The Division will work with various consumer and advocacy organizations to develop strategies and materials to ensure better consumer knowledge on parity topics.

K. Primary and Behavioral Health Care Integration Activities

Narrative Question: Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. *Describe your involvement in the various coordinated care initiatives that your state is pursuing.*
2. *Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?*
3. *Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?*
4. *Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.*

Primary and behavioral health care integration activities have revolved around collaborations between DMH/DD/SAS and LME/MCOs with Community Care of North Carolina (CCNC). A partnership between NC DHHS and 14 independent networks consisting of 4,500 physicians in 1,360 primary care practices, CCNC currently provides a health home for over 1.27 million NC Medicaid patients. CCNC and LME/MCOs collaborate at the local level on care coordination activities for individuals with severe mental health disorders and/or co-occurring addiction and chronic medical conditions. Physician leaders from all 14 networks design and develop initiatives to improve health outcomes. The following initiatives are currently underway: asthma disease management; congestive heart failure disease

management; diabetes disease management, Emergency Room Initiatives; and, case management of high risk/high cost patients.

In 2011, DMH/DD/SAS was awarded a five-year \$8.33 million grant from SAMHSA for funding to design and implement a state-level SBIRT (screening, brief intervention, referral and treatment) program in NC. This project is a collaboration of DMH/DD/SAS, the Governor's Institute on Substance Abuse and CCNC. Over the next five years, SBIRT NC plans to serve over 37,000 adults across 13 counties, with the subsequent intent to expand to all 14 CCNC networks. Patients who screen positive for alcohol and substance use through alcohol and drug screening tools are also assessed and treated for depression and other mental health disorders by clinicians on-site (at the primary care practice) or referred for specialty treatment.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

NC DHHS screens, assesses and provides treatment options for smoking and other unhealthy behaviors at state psychiatric facilities.

6. Describe how your behavioral health providers are screening and referring for:

- a. heart disease,*
- b. hypertension,*
- c. high cholesterol, and/or*
- d. diabetes*

The Division of Medical Assistance requires through Clinical Coverage Policy 8-C, that all comprehensive clinical assessments include information on an individual's chronological general and medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable for all consumers and adherence is reviewed and monitored annually through block grant monitoring reviews.

A behavioral health care provider recently received funding from SAMHSA for a Primary Care Behavioral Integration project that employs a physician assistant in one site and collaborates with CCNC in three other sites to screen and refer consumers seen at its clinic for behavioral health disorders for heart disease, hypertension, high cholesterol and/or diabetes. In addition, most LME/MCOs have approved the use of Evaluation and Management (E and M) codes by their contracted providers, which provide for a more thorough medical and/or physical examination, in conjunction with presenting behavioral health conditions.

L. Health Disparities

Narrative Question: In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language

primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities. While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

Access and enrollment in services is captured via data submitted to the Client Data Warehouse (CDW), which is required of all LME/MCOs at the time an individual is screened for services. In addition to identifying up to three presenting problems, race, ethnicity, gender, age, military status and accommodations for special needs, such as a need for interpreters either for foreign languages or American Sign Language, visual impairment, mobility issues, childcare, etc., individuals are provided an appointment with a provider of their choosing.

Once connected to a provider, individuals participate in NC TOPPS, which is administered during the initial appointment as well as at regular intervals throughout the individual's course of treatment. Questions on NC TOPPS include those mentioned above, as well as a question related to "difficulty entering treatment because of problems with . . . language or communication issues, stigma or embarrassment, deaf or hard of hearing." Compilation of this data will allow us to measure access and retention in treatment by race, ethnicity, gender and age.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

The state can identify language needs through data collected at the time of screening and reported via the CDW. As mentioned earlier in this document, LME/MCOs are required to conduct a community need and provider capacity assessment using a standardized process and reporting format defined by the Secretary. The assessment takes into consideration the population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age disability providers for each service. The assessment includes input from consumers, families, community stakeholders and CFAC. In evaluating the adequacy of the provider community, the LME/MCO considers issues such as the cultural and linguistic competency of existing providers. The LME/MCOs report the results of the assessment to DMH/DD/SAS, provide updates as needed and must demonstrate their engagement in development efforts to address service gaps identified in the assessment. If the gaps analysis identifies an absence of provider(s) for any MH/DD/SA service, the LME/MCOs submit a plan for developing a local provider community that offers choice for each service in their catchment areas in the next state fiscal year.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

The Division will review the community need and provider capacity assessments from each LME/MCO to determine the breadth of needs and gaps in this specific area and also review the LME/MCOs' plans to address those gaps. Analysis of this information is the first step in determining a process for addressing and eventually reducing disparities in access, service use and outcomes for this sub-population across the state.

M. Recovery

Narrative Question: SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

The state is in the process of initiating the development of a state-level Recovery Policy that is consumer-driven and developed through an inclusive process so that the authenticity of recovery concepts becomes a shared value of consumers, service providers and administrators. The first step was a Recovery Summit in March 2013 that gathered stakeholders to begin dialogue and make recommendations for recovery integration (mental health and substance abuse), recovery in practice (clinical services, consumer-operated services) and recovery in policy (managed care, state level). In planning this Summit, the state is receiving technical assistance from SAMHSA's BRSS TACS initiative and working with other SAMHSA-funded statewide Consumer and Family Network grant recipients to promote recovery.

Additionally, the US DOJ Settlement Agreement calls for ensuring that the state develops a Recovery-Oriented System of Care. It states *"Individuals have access to the array and intensity of services and supports they need to successfully transition to and live in community settings, including supported housing. Such services and support shall: be evidence-based, recovery-focused and community-based."*

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

No, while individuals may self-disclose, North Carolina state government does not solicit or track such information.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

The policy of the NC Division of MH/DD/SAS is that the Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. The plan focuses on the identification of the individual's needs and desired life outcomes, not just a request for a specific service(s). The Qualified Professional responsible for the development of the PCP must assure that the plan captures all goals and objectives and therefore supports good action and crisis planning. The plan captures long term and short term outcomes, goals and objectives, including detailed information regarding justification for continuation, modification or termination of a goal and it outlines each team members' responsibilities within the plan.

Since the inception of the Person-Centered Plan (PCP) in 2006, the NC Division of MH/DD/SAS has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the PCP, the Division of MH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as monitored public opinion. Subsequently, the PCP format has been redesigned over the last five years, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available and evaluative information that has provided new direction for the planning process.

The person-centered planning process champions strengths and recovery and applies to everyone supported and served in the public mental health, developmental disabilities and substance abuse services system. Person-centered planning provides for the individual with, or the family of a person with, a disability assuming an informed and in-command role for life planning, service, support and treatment options and sharing authority and responsibility with system professionals about decisions made.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

North Carolina has not received any **Access to Recovery** grants or funding, which has limited our ability to develop the robust recovery system that we envision. Some services, such as recovery support coaching, warm lines, recovery housing, and supported employment are available, but not at the breadth and depth needed.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

A statewide Peer Support Services policy is being developed to ensure it is consistent across the state and it is recovery-focused and evidence-based. The stakeholder workgroup includes Certified Peer Support Specialists, peer support providers and other advocates.

Peer Supports has been added to the Medicaid State Plan Amendment and is now included as a Medicaid 1915 (b)(3) service. In addition, as part of the Settlement Agreement with the U.S. Department of Justice, Peer Supports have been included in a variety of new functions. Certified Peer Support Specialists will be hired as “In Reach” specialists for assertive engagement of individuals living in adult care homes and hospitals. They are required staff for ACT teams. They will be hired in Supported Employment programs as “Employment Peer Mentors” and as “Tenancy Support Specialists” to help people gain and maintain independent living skills in order to better assure community integration.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes, the Division supports the above through the contract with the Governor’s Institute on Substance Abuse and is operationalized through trainings offered on Recovery Oriented System of Care through the Behavioral Healthcare Resource Program, UNC School of Social Work.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

In 2006, the state developed and implemented the NC Certified Peer Support Specialist program (NCCPSS) to train and certify peer specialists. DMH/DD/SAS provided six LME/MCOs with funding from the Mental Health Trust Fund to train a minimum of 120 peer support specialists, so that they will meet the criteria to apply for full certification as a Certified Peer Support Specialist (CPSS) in NC. Peer specialists have been hired by providers and LME/MCOs to provide peer support and assist in various projects to promote advocacy and empowerment of consumers and family members. The state has also developed a web-based course designed to assist managers and supervisors wishing to enhance their skills supervising NC Certified Peer Support Specialists. All approved courses under this program are guided by recovery principles, national research and best practice reports (e.g., Pillars of Peer Support) and the evidence-based practice delineated in SAMHSA’s consumer-operated services toolkit. Currently, there are over 800 certified Peer Support Specialists (CPSS) in the state.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Peer Support is included in at least three of the state’s reimbursable service definitions: Assertive Community Treatment Team, Community Support Team and Social Support Detoxification. In

addition, several LME/MCOs have promoted recovery-oriented services and are reimbursing for these services through alternative service definitions and through PATH funds.

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

DMH/DD/SAS has developed policy DO 112, *Consumer and Family Member Volunteer Appointment to DMH/DD/SAS Workgroups and Committees*. This policy was developed so that all interested individuals have an equal opportunity to participate in the policy and decision making bodies of the system. Notices of all volunteer opportunities are posted on the Division website at <http://www.ncdhhs.gov/mhddsas/services/advocacyandcustomerservice/volunteer.htm> and are also sent out to a mass mailing of all local Consumer and Family Advisory Committees (CFACs) and other grass roots organizations. This policy was developed due to the desire of DMH/DD/SAS to have consumers and family members on all internal and external workgroups related to policy development. Any time a DMH/DD/SAS committee or workgroup needs assistance locating a consumer or family member for participation in their group, this policy is followed. Also LME/MCOs are encouraged to utilize either their local consumer and family advisory committee members or other individuals in recovery to assist in planning at the local level.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

The State sponsors meetings that identify individual and family members' issues and needs regarding the behavioral health system and has developed a process for addressing these concerns. As noted above, policy DO 112, *Consumer and Family Member Volunteer Appointment to DMH/DD/SAS Workgroups and Committees*, was developed so that all interested individuals have an equal opportunity to participate in the policy and decision making bodies of the system. Notices of all volunteer opportunities are posted on the Division website at <http://www.ncdhhs.gov/mhddsas/services/advocacyandcustomerservice/volunteer.htm> and are also sent out to a mass mailing of all local CFACs and other grass roots organizations. Members of the Consumer Empowerment Team (CET) of the Division attend all local CFAC meetings and have developed connections with individuals and local advocacy organizations in each of the catchment areas. CET members routinely inform their individual contacts about opportunities for inclusion and participation in the ongoing development and monitoring of the mental health, developmental disability and substance use service system.

The state provides funding and supports for existing consumer, family and youth organizations to expand self-advocacy, self-help programs, support networks and recovery oriented services. The state has provided funding to North Carolina Families United (NCFU), a statewide family organization, to

produce a training curriculum for families and service providers on how to implement system of care principles and how to choose service providers for youth and their families. With support from the block grant, NCFU has funded and trained Family Support Partners and specialists.

In addition, the state has legislation requiring consumer and family participation at the state and local level. NC General Statute 122C-171 *State Consumer and Family Advisory Committee* (SCFAC), enacted in 2006, requires consumer and family member participation at the state and local level. The SCFAC functions as a consumer advisory board to DMH/DD/SAS and the General Assembly. A Consumer and Family Advisory Committee (CFAC) is similarly required at each LME/MCO to review, comment on and monitor the implementation of the local business plan; identify service gaps and underserved populations; make recommendations regarding the service array and monitor the development of additional services; review and comment on the LME/MCO's program budget; participate in all quality improvement measures and performance indicators; and, submit to the State CFAC findings and recommendations regarding ways to improve the service delivery system.

Consumers and family members are involved in several advisory and policy committees. The External Advisory Team (EAT), comprised of advocates, consumers, provider trade associations and other stakeholders, meets monthly to provide advice and guidance on policy decisions. Members from the SCFAC meet monthly with the DMH/DD/SAS Executive Leadership Team (ELT) to present and receive information currently of interest to both groups. The state has supported the State Family and Consumer Advisory Committee in their bi-monthly conference calls with local CFACs since January 2011 to educate consumers and family members about ongoing changes related to the 1915 (b)/(c) waiver. The NC DHHS Waiver Advisory Committee (DWAC) is a monthly meeting of stakeholders, which includes consumers and family members. These stakeholders serve to provide information to DHHS regarding the implementation of waiver services. A bi-monthly Advocates Committee is held to discuss any issues. Consumer and family members serve as representatives on the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.

DMH/DD/SAS requires LME/MCOs to seek consumer and family involvement in additional committees and forums. These committees include the LME/MCO Area Board, Quality Management and Client Rights Committees. LME/MCOs host community forums to provide information about changes in services and to obtain information about gaps and needs in services. Suggestions and input from consumers and families help the LME/MCOs to develop their services and determine how funding should be allocated.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Staff of the Division's Advocacy and Customer Service section has educated consumers and family members of their rights and opportunities to advocate for services. The Consumer Empowerment Team (part of the Advocacy and Customer Service section) presents information to local community groups, such as CFAC, on how to access services in their local communities. The Consumer Empowerment Team will continue to expand their contact beyond CFACs to grass roots organizations,

faith-based organizations and other community groups to develop a large network of advocates across the state.

The state has provided technical assistance and funding to LME/MCOs so that they can conduct Crisis Intervention Training (CIT) in their local communities in order to educate law enforcement officers. In addition, local CFAC members participate on the CIT panel presenting information relevant to interacting/living with persons with disabilities.

Information on local support groups, advocacy organizations at the state and federal level and various self-help options are posted on the DMH/DD/SAS website. DHHS and DMH staff members meet monthly with advocates to discuss ongoing issues across the state.

The state has provided funding for Recovery Education Centers (RECs) that focus on evidence-based practice curricula designed to build recovery skills or wellness recovery practices. The Division has provided funding to two consumer-run organizations which teach advocacy skills and provide ongoing support to their members: the NC Mental Health Consumers Organization and the NC Association of Self Advocates. Some LME/MCOs use state dollars to provide funding and support to local NAMI Chapters and NC First in Families to provide ongoing education and support to their members. Some LME/MCOs also provide meeting space and other types of support for 12-step programs and other peer support and self-help groups.

Since 2009, the state has funded and helped to plan and host a statewide Recovery Conference. We are currently planning the Fifth Annual Recovery Conference which is partially funded by the SABG. As described on the SAMHSA Recovery Month website, the Annual Recovery Conference is “designed to foster the continuing growth of the North Carolina Recovery Movement, to teach participants how to get recovery programming up and running in their own communities, to showcase some of the most progressive recovery practices and to bring the community of providers and individuals in recovery together as students and partners. This conference is designed to educate and motivate participants to apply principles of recovery in their personal and professional lives.”

DMH/DD/SAS also hosted a statewide Recovery Summit on March 27, 2013. Consumers, family members, advocates and individuals interested in promoting recovery principles were invited to the Summit to provide information to develop a statewide definition for recovery and provide suggestions for methods to promote the incorporation of recovery principles in all aspects of behavioral health services. Members of this summit were invited to be part of a Recovery Coalition which will serve as an advisory group to DMH/DD/SAS.

DMH/DD/SAS has developed a number of funding mechanisms to ensure people in the community in recovery from mental illness and/or substance use have access to peer support. In addition to developing Medicaid service definitions for Peer Support, a number of state funded “alternative” service definitions have been developed.

The state has established a process for persons to become certified as Peer Support Specialists. Consumers and family members have consistently been engaged in the processes of developing

standards for certification of Peer Specialists, the development of a Code of Ethics for Peer Support Specialists and other policy decision regarding the certification of peers. As of April 2013, there were eight hundred seventy-one (871) persons in North Carolina certified as Peer Support Specialists. In 2011 the Division used Mental Health Trust Funds to pay for the training of one hundred fifty- five (155) persons as Peer Support Specialists, of which one hundred and thirty-one (131) became certified.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

The State of North Carolina entered into a settlement agreement with the United States Department of Justice (USDOJ) on August 23, 2012. The purpose of this agreement is to assure that persons with mental illness are allowed to reside in their communities in the least restrictive settings of their choice. This Agreement is intended to ensure the state will meet the requirements of the ADA, the Rehab Act, and the *Olmstead* decision, which require that services offered to individuals with disabilities shall be provided in the most integrated setting appropriate to meet their needs. While this settlement agreement was designed to address specific *Olmstead* issues, it is the desire of the Division that this will provide the infrastructure for a more comprehensive housing response and plan. An integral component of the agreement includes the utilization of peers as "In Reach" Specialists who provide in reach services to individuals residing in adult care homes who may desire more independent housing options. These In Reach Specialists, typically either directly employed by the LME/MCOs or under contract through a provider agency, will play a vital role in transitioning individuals to less restrictive settings.

For the past several years, each LME/MCO has had a contractual requirement to have at least one FTE designated as the Housing Specialist for their catchment area. The responsibilities of the Housing Specialist, which encompass all disability groups, include the following broad categories:

- Serve as Lead Agency for the Targeting Program and the Housing 400 Initiative to ensure DMH/DD/SAS tenants have the support services they need in addition to affordable housing;
- Actively participate in the local Continuum of Care (US Department of Housing and Urban Development housing programs that provide units for DMH/DD/SAS consumers who are homeless) by engaging in activities that support the expansion of housing opportunities to ensure DMH/DD/SAS consumers have access to Continuum of Care housing units;
- Develop and annually update a Strategic Housing Plan that includes an inventory of local, existing housing for DMH/DD/SAS consumers; the housing needs of DMH/DD/SAS consumers; strategies for filling the gap between existing housing and housing needs; barriers to implementing those strategies; and means for assessing implementation of the Strategic Housing Plan;
- Participate in the quarterly meetings for Housing Specialists that are offered by DMH/DD/SAS;

- Educate and be a resource for MH/DD/SAS professionals, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, regarding the NC Landlord-Tenant and Fair Housing laws and on negotiating reasonable accommodations;
- Develop a positive working relationship with local public housing authorities and HUD Section 8/Housing Choice Voucher administrating agencies to improve access and increase the supply of these resources;
- Establish partnerships with other local, affordable housing and MH/DD/SAS advocates to improve access and increase the supply of resources for MH/DD/SAS consumers;
- Develop and maintain an internal wait list for consumer referrals to housing resources that have referral relationships with the LME/MCO; and
- Work with other agencies to identify and secure housing and support services funding opportunities from private, city, county, state and federal sources.

Many of the above responsibilities speak to systemic progression. In addition, each LME/MCO has the capacity to develop alternative service definitions to better meet specific needs of their geographic areas. For example, some LME/MCOs have developed service definitions that provide a reimbursement mechanism for contracted providers to maintain contact and provide supportive services to individuals (that do not meet medical necessity criteria for higher levels of care) in independent housing settings. This helps assure that individuals have the necessary supports in place to remain in less-restrictive settings.

In addition, NC will be implementing a new definition for Assertive Community Treatment (ACT) that will assist individuals with co-occurring mental illness and addiction in a supported community model. While ACT is provided across the state currently, prior to these changes there was no specific enforcement on team size and functional operations. The new rule will clearly define how an ACT team is to operate, will require teams to maintain fidelity to the model and will such be monitored by Division staff.

Oxford Houses help fill the gap for peer operated recovery homes and provide a level of support not found in other settings. Specifically, this model provides for community-based, integrated housing that is safe, affordable and drug-free, with the support of peers in recovery and Oxford House staff. It also encourages utilization of other services and supports in the community that promote recovery and self-sufficiency. For many recovering substance abusers who are re-entering society, Oxford Houses will serve as tools of transition. By providing a place to live with supportive services, Oxford Houses reduce the risk of relapse among ex-offenders and other residents. As of February 2013, there were 153 houses in North Carolina with locations in 29 cities. With the 153 houses, Oxford House has the capacity to assist more than 1,140 North Carolinians recovering from substance use disorders. House members split house expenses, which average \$90.00 - \$125.00 per person per week.

For SFY 12-13, the Division continued to work successfully with Oxford House, Inc. and allocated \$450,000 in federal funds to finance the contract with Oxford House, Inc. The major purpose of this

contract was to support Oxford House in opening eight new houses and to provide technical assistance and support for the establishment of these self-run, self-supported recovery homes throughout the State of North Carolina by the end of the contract period.

Although Oxford House, Inc. currently provides more than 1,140 beds or units for persons recovering from addiction, an unmet need remains throughout North Carolina. This fiscal year applications for Oxford House units per month exceeded admissions per month by an average of 96 units.

According to the Oxford House North Carolina Resident Survey conducted in June 2012, a reported 78 percent of the residents in Oxford Houses had served time in jail or some correctional facility an average of 21 months. During this survey period, 62 percent of all the Oxford House residents had experienced homelessness averaging approximately five months. Most houses had accepted parolees and probationers as residents within the prior year. From July 1, 2005 to December 31, 2012, Oxford House Criminal Justice outreach staff has placed 623 men and women in Oxford Houses, exceeding its expectations. In addition, over 1,125 applications were taken which supported Oxford House in exceeding the goal of serving at least 20 re-entering individuals per year.

Oxford House, Inc. also maintains the North Carolina Recovery House Revolving Loan Fund by administering the application, administration and repayment of start-up loans made to eligible applicants of eight or more recovering individuals. This revolving loan fund provides up to \$4,000 per house to use to cover start-up costs, which is an essential resource for many recovering individuals who do not have sufficient financial means for securing safe, affordable housing on their own.

N. Prevention

Narrative Question: As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental

strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

- 1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?*

The Prevention and Early Intervention Team within DMH/DD/SAS has utilized data from several sources, including the North Carolina Prevention Outcomes Performance System (NCPOPS), National Study of Drug Use and Health (NSDUH), North Carolina State Epidemiological Report (2012) and the North Carolina Social Indicator Study Report (2011, 2012) State Epidemiological Outcome Workgroup (SEOW), NC IOM reports and research, etc. We have used the risk and protective factor framework since the 1990s to assist us with planning for prevention services. Because risk factors are precursors of substance abuse, social indicators have been used for many years for both research and planning purposes. The risk and protective factor framework has been particularly important for developing data-driven approaches to prevention; reducing risk factors or protecting against them can prevent the occurrence of such behaviors. Technical assistance needs were identified through data received from some of the sources mentioned above. Data revealed the need for technical assistance to communities and prevention providers around the five steps of the Strategic Prevention Framework, workforce development, model fidelity, alcohol and tobacco policy, prescription drug abuse, parenting education, family programs and evaluation.

- 2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?*

The state will continue to fund universal, selective and indicated evidence based practices, programs and policies via information dissemination, education, alternatives, problem identification and referral, community-based processes and environmental strategies. Prevention providers will use local needs assessments to determine the substance abuse prevention needs and appropriate activities and strategies for their communities. A comprehensive community plan utilizing all five steps of the Strategic Prevention Framework (SPF) will be submitted to the Prevention and Early Intervention Team for review, technical assistance and approval. Prevention providers will use the National Registry of Evidence-based Practices and Programs (NREPP) system to identify potential evidence-based curricula and the Prevention and Early Intervention Team will consult and provide technical assistance to select and implement the most appropriate and cost effective programs for the communities. Providers are required to submit all other funding sources of primary prevention activities via the Semi-Annual Substance Abuse Prevention Treatment Block Grant Compliance Report (due in January and July) and within 30 days of receipt of funding if it is received after the reporting period.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Establishing capacity is a key strategy for the promotion and sustainability of substance abuse prevention programs. Capacity building allows for the exchange of data and ideas, skills to effectively address prevention needs and physical resources to meet that need. The Division will continue to fund the Centers for Prevention Resources to assess training and technical assistance needs for communities and providers, coordinate regional networks through meetings and trainings, increase training opportunities for substance abuse prevention at regional and statewide conferences and coordinate additional local and regional trainings as needed, assist communities with the development of logic models based on their local contributing factors and assess cultural competence and sustainability and develop plans for their communities. The Prevention and Early Intervention Team will continue to utilize Partnerships, Alliances, Coalitions and Collaboratives (PACCS) as a conduit to encourage resource sharing and community mobilization. We will also continue to utilize the state prevention outcome performance system (NCPOPS) to collect and analyze data from substance abuse prevention providers.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

The Prevention and Early Intervention section will continue to collect the required NOMS and demographic data. We will also continue to identify any trends and gaps in service that need to be addressed.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

The SPF process has guided the SPF-SIG, SPE and SEOW grants that the state has received as well as training and technical assistance to local communities.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

None of the SABG prevention set-aside goes to the state.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

The Division anticipates that for FY 14, with an expected prevention set-aside amount of \$7,823,543, approximately \$6,575,474 will be spent on best practices and environmental strategies. See the list in the table below.

EBP	IOM Classification
Project Alert	Selective
Lifeskills	Selective
Project Toward No Drug Abuse	Selective
I'm Special	Selective
Reconnecting Youth	Indicated
Early Risers Skills for Success	Indicated
Active Parenting Now	Selective

Strengthening Families 6-11	Selective
Strengthening Families 10-14	Selective
Allstars	Selective
Nurturing Parent	Selective
Allstars Jr.	Selective
Dare to Be You	Selective
Hip Hop to Prevent SA?HIV	Selective
Positive Action	Selective
Project Success	Selective
Keepin it Real	Selective
Parenting Wisely	Selective
Storytelling for Empowerment	Selective
Project Venture	Selective
Staying Connected to Your Teen	Selective
Children in the Middle	Selective
Good Touch, Bad Touch	Selective

O. Children and Adolescents Behavioral Health Services

Narrative Question: Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

- 1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?*

North Carolina has a long system of care (SOC) history that stretches back to 1980 with a program for assaultive children that followed a class action lawsuit in which the class was determined to not be receiving appropriate services. The stipulations of the lawsuit settlement—that children meeting the

class criteria had the right to individualized treatment in the least restrictive setting possible (NC DHHS, 1999) became the foundation for state and national child mental health initiatives that followed.

SAMHSA CMHS-funded projects have led to the adoption and infusion of SOC philosophy and guiding principles in each of the State Plans of DMH/DD/SAS beginning in 2001. It also led to the founding of a statewide family organization (now North Carolina Families United) that was led by Sandra Spencer, currently Executive Director of the National Federation of Families on Children's Mental Health. The grants allowed sustained evaluation through the inclusion of indicators in the state's web-based system (NC TOPPS) for collecting data on people with substance abuse and mental health disorders served through the system. The founding of the State Collaborative (now known as the North Carolina Collaborative for Children, Youth and Families) in 2001 is another significant achievement. Composed of representatives from state agencies, family and youth organizations, advocates, universities and colleges and other community members, the State Collaborative acted as the advisory body for the original grants and other grants obtained by the state and local agencies. The State Collaborative also offers a forum to discuss SOC development and issues and provides support for local collaboratives and child and family teams. DMH/DD/SAS further received a three-year **Adolescent Treatment and Coordination** grant in 2005 that provided System of Care training to providers of substance abuse services for children and youth. With the end of grant funding for the first three SOC demonstration projects in 2007, the NC General Assembly began providing recurring funds of two million dollars per year for System of Care Coordinator positions at the state and local levels.

DMH/DD/SAS is currently applying for funding from SAMHSA to develop a comprehensive strategic plan that will strengthen, enhance and expand SOC for children and youth with serious emotional disorders and their families in North Carolina. The plan will be developed in close partnership with youth and families and in collaboration with child welfare, education, juvenile justice, substance abuse, primary care and other child-serving organizations. The goals will focus on the development of a strategic plan in the context of the managed care environment of the state's public service delivery system for mental health that will address health reform, the continuum of services, family and youth organizations and collaboration among agencies that will extend beyond the grant funding period. DMH/DD/SAS and its partners are committed to developing the plan regardless of whether the application is funded.

The State Collaborative for System of Care now generates its own funding through an online SOC training for providers that it developed through the collaboration of agencies and family and youth. And most importantly, the strategic plan that will be developed through the proposed project will be integrated into the state plan, the plan for the CMHS Block Grant and the plans of agencies and family/youth programs to provide continuity long beyond the end of the funding period.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

North Carolina has guidelines for individualized care planning for children and youth with mental, substance use and co-occurring disorders. The System of Care Coordinators at the LME/MCOs have all been trained in individualized care planning, particularly through child and family teams. The State

Collaborative for Children, Youth and Families further developed an online training for providers with the collaboration of families, youth and representatives from child- and youth-serving agencies on SOC that includes individualized training.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

DMH/DD/SAS collaborates with other child- and youth-serving agencies on initiatives where the population of focus is children with a severe emotional disturbance and/or co-occurring substance use who are generally involved with multiple agencies. For instance, the agency collaborates with the Department of Juvenile Justice and Delinquency Prevention on the Juvenile Justice Substance Abuse Mental Health Partnership (JJSAMHP). The agency also collaborates with the Department of Public Instruction on a SAMHSA-funded Suicide Prevention Program, with the Department of Health on Project LAUNCH and with Department of Social Services on a SAMHSA-funded trauma-focused grant for children and youth in foster care.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

The state provides training in evidence-based mental and substance abuse prevention, treatment and recovery services for children, adolescents and their families through the Area Health Education Programs, through LME/MCOs, through organizations such as NAMI and through universities using state or block grant funds. Evidence-based practice training for providers is also offered by LME/MCOs and by provider organizations.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The state will monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders through an analysis of paid claims for services submitted by providers, as well as NC TOPPS data.

P. Consultation with Tribes

Narrative Question: SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for

tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

According to the 2000 census, North Carolina has one of the largest American Indian populations east of the Mississippi and the eighth largest population in the nation exceeding 120,000 for eight **state** recognized tribes (Coharie, Eastern Band of Cherokee (also federally recognized), Haliwa-Saponi, Lumbee, Meherrin, Ocaneechi Band of Saponi, Sappony and Waccamaw Siouan) and four urban American Indian organizations (Association for Indian People, Guilford Native American Association, Metrolina Native American Association and Triangle Native American Society). American Indian population growth exceeds that of many other ethnic groups in the state.

The DMH/DD/SAS has a 25-year partnership with the NC Commission on Indian Affairs. Both agencies collaborate with each other to convene bi-monthly meetings to engage the eight tribes and four urban associations in determining needs, planning and capacity building, implementation and evaluation of mental health and substance abuse services for Native Americans in North Carolina. The Prevention and Early Intervention Team (PEI) provides consultation, technical assistance and resources to the Commission to assist it in accomplishing the goal of providing appropriate and quality services in the areas of mental health and substance use. In addition, the Commission on Indian Affairs has participated in the advisory board for prevention services, the Cooperative Agreement Advisory Board (CAAB) and the statewide Fetal Alcohol Syndrome Disorders Coalition.

PEI has led the efforts of DMH/DD/SAS to collaborate with the NC Commission on Indian Affairs to fund several substance abuse prevention initiatives in the past and is collaborating with them to establish Partnerships, Alliances, Coalitions and Collaboratives within the Native American communities. The Native American Substance Abuse Prevention Initiative seeks to develop the Native American substance abuse prevention workforce and provides funding for evidence-based curricula and professional development training to staff of the initiative. Substance abuse prevention activities and strategies include a community and school-based program that will provide substance abuse prevention education to Native American parents and children. This program seeks to increase the awareness of the effects of drugs and alcohol in the Native American community. Efforts thus far have targeted Robeson County, where the Native American population has experienced a high rate of alcohol abuse, death by motor vehicle and death by motor vehicle while under the influence of alcohol. This program will work within the community and school structures to provide programs and activities that will empower participants to make healthier decisions about drug and alcohol use. The program will work within existing structures to collaborate with groups such as the Lumbee Tribe that hosts a variety of programs targeted toward the Native American community. The substance abuse block grant funds two FTEs at Robeson Health Care to work specifically on this initiative.

Although gambling has been an important and multi-functional element in Cherokee culture, current issues regarding problem gambling as it impacts families and the community are of interest to tribal agencies and leaders. The North Carolina Department of Health and Human Services (NC DHHS) is funding a needs assessment that will assist and inform agencies serving tribal members and their

community. Through this grant, the Center for Native Health is working closely with Analenisgi, the tribe's behavioral health program to develop programmatic strategies to benefit the Eastern Band of Cherokee Indians (ECBI). DHHS has provided training for ECBI members in the **Stacked Deck** curriculum, which is listed on SAMHSA's NREPP website. **Stacked Deck** is offered to students in grades 7-12, as well as youth being served at the substance abuse treatment center, Unity Healing Center, in Cherokee, NC.

The NC FOCUS on Service Members, Veterans and Their Families recently participated in a Veterans Policy Academy sponsored by SAMHSA. Members of the team that participated in that academy and that will continue to work on plan implementation include state representatives as well as Cherokee nation and Lumbee tribe veterans.

Q. Data and Information Technology

Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked each state to: Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;

- 1. List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;*
- 2. Provide information regarding its current efforts to assist providers with developing and using EHRs;*
- 3. Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and*
- 4. Identify the specific technical assistance needs the state may have regarding data and information technology.*
- 5. Please provide an update of your progress since that time.*

The state provides specific information on services and individuals funded through the block grants through its Integrated Performance and Reporting System (IPRS). Built upon the existing Medicaid Management Information System (MMIS), IPRS is used to track, pay and report on all claims submitted by providers for services rendered that are eligible for state and federal grants funding, including the Substance Abuse Prevention and Treatment Block Grant.

The state collects performance indicators information through the Client Data Warehouse (CDW) from LME/MCOs and client level data through the web-based NC TOPPS.

Through data infrastructure grants, the Division developed database structure and definitions in its two client data warehouses, the DMH Client Data Warehouse (CDW), which is the Division level production database, and the Client Services Data Warehouse (CSDW) which is the enterprise level web-based decision support database. Currently the system has the capability of web-based reporting, utilizing data from the Perception of Care surveys, Medicaid, Integrated Payment and Reporting System (IPRS), the client information systems of LME/MCOs, the billing and information system of the Health Enterprise Accounts Receivable and Tracking System for State Facilities (HEARTS) and archived data. Reports based on databases are produced through corporate or ad-hoc queries and are disseminated to end-users. The Division produces the Community Systems Progress Report (CSPR) based on Medicaid and IPRS claims data, LME/MCO reported data, access data, and state hospital data including the alcohol and drug abuse treatment centers (ADATCs) from the CDW reports. This report monitors the

LME/MCOs' performance on the critical performance measures (timely initiation and engagement in service, timely follow-up after inpatient care, etc.) against statewide averages and the performance standards in the *DHHS-LME Performance Contract* for services to persons in need by age and disability.

In December 2008, the North Carolina Department of Health and Human Services (DHHS) awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a Replacement Medicaid Management Information System (NCMMIS+) in support of healthcare administration for multiple DHHS agencies. NCTracks, the Replacement NCMMIS+, will be used by the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the Division of Public Health (DPH), the Migrant Program for the Office of Rural Health and Community Care (ORHCC) and the Division of Health Service Regulation (DHSR). NCTracks will process health care claims for about 70,000 enrolled DHHS providers who serve over a million North Carolina citizens.

NCTracks is a multi-payer system that will facilitate provider enrollment and consolidate claims processing activities for multiple DHHS health plans. Providers enrolled in DMA, DPH and ORHCC health plans will submit claims for covered health care services to NCTracks. Providers who are contracted by LME/MCOs to perform state funded MH/DD/SAS services will continue to submit their claims to the LME/MCO. NCTracks will coordinate processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim.

DHHS Division	Health Plan
DMA	Medicaid (including Behavioral Health)
DMA	NC Health Choice
DMH/DD/SAS	State Controlled/Funded Mental Health Services
DMH/DD/SAS	State Controlled/Funded Developmental Disabilities Services
DMH/DD/SAS	State Controlled/Funded Substance Abuse Services
DPH	Public Health

ORHCC	Rural Health
ORHCC	Migrant Health Program

As part of the NCTracks contract, on April 20, 2009, CSC assumed responsibility for enrollment, credentialing and verification activities for provider participation with NC Medicaid. These activities were previously carried out by DMA Provider Services. All providers will be uniquely identified by an NPI number and taxonomy codes.

In NCTracks, all agencies in DHHS will be using the North Carolina Common Name Data Service (CNDS) to uniquely identify recipients of services across the DHHS divisions.

The NC Treatment Outcomes and Program Performance System (NC TOPPS) is a web-based system for gathering outcome and performance data on behalf of mental health and substance abuse consumers in North Carolina's public system of treatment services. NC TOPPS provides reliable information that is used to measure the impact of treatment and to improve service and management quality throughout the service system. NC TOPPS was launched in 1997 as a partnership between the federal government and the state to implement a system for monitoring and evaluating substance abuse treatment services. In 2005, mental health services were added and the system was moved to a web-based format.

DMH/DD/SAS has an ongoing contract with the Knowledge-based Information Technology Solutions (KIT Solutions) to implement and support a management system for the collection, management and analysis of prevention data for the SA Block Grant. Through its Strategic Prevention Framework-State Incentive Grant, NC added a module to the KITS system for collection of coalition and intervention data.

R. Quality Improvement Plan

Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Through the implementation of **DHHS Excels**, the divisions within DHHS have placed a predominant focus on improving quality and demonstrating effectiveness through a responsive system of care. The Division of MH/DD/SAS and LME/MCO functions employ administrative operations and service delivery based on principles of Continuous Quality Improvement/Total Quality Management

(CQI/TQM). These CQI processes identify and track critical outcomes and performance measures with the most reliable data the state system has access to. The state uses this process and data to inform needed changes, identify gaps, needs and strengths that can be used to describe the health of the mental health and addiction systems.

DMH/DD/SAS has a Quality Management Team that was established with its reorganization in 2003 when evaluators and researchers were brought together from various branches of the Division to create a framework for the evaluation of the service delivery system, determine performance measures and systematize data collection and reporting, among other functions. Since then, the QM Team has participated in the development of the DMH/DD/SAS Client Data Warehouse (CDW), refined the collection of National Outcomes Measures for the Mental Health Block Grant through a series of Data Infrastructure grants, expanded the NC Treatment and Outcomes Program Performance System (NC TOPPS) and implemented a web-based substance abuse data collection tool for prevention services under a contract with the Knowledge-based Information Technology Solutions (KIT Solutions). The QM Team disseminates reports directly to the DMH/DD/SAS Executive Leadership Team at its monthly meetings and through the DMH/DD/SAS website to show system performance on various measures, including the National Outcomes Measures (NOMS), at the State, LME/MCO and county level quarterly, annually or in real time with its dashboard measures. The QM Team also is responsible for the reporting of indicators required by both the Mental Health and Substance Abuse Prevention and Treatment Block Grants.

As mentioned above, at the broader level, North Carolina's Department of Health and Human Services has initiated a quality improvement program, ***DHHS Excels*** that brings together the work of all divisions within the department under five goals. The goals cover (1) infrastructure and resources, (2) public education and universal prevention, (3) targeted prevention, (4) treatment and services to help individuals stay in their home communities, and (5) treatment and services for those who need intensive (inpatient) services to help them return to their communities. These goals drive performance measurement for all DHHS divisions. The Division is using this initiative to shape performance goals and measures for LME/MCOs and providers of MH and SA services as well.

North Carolina uses a combination of process, output and outcome measures to evaluate the quality of care and progress on state initiatives at the local and state level. The Division uses the performance trends and patterns across the state to target training, service development and other initiatives to improve the service system.

Policies and procedures regarding adverse consumer events, complaints and grievances are outlined in administrative rules that tie response to local monitoring and investigation of providers. Response is expected to be initiated at the most immediate level, with successive look-behinds and back-up procedures in place to ensure appropriate actions are taken. The Division developed and implemented a statewide Incident Response and Improvement System (IRIS) in SFY 2010 that is utilized by LME/MCOs and sister agencies at the state level to ensure appropriate, timely response to critical incidents by providers, LME/MCOs and state oversight agencies. The system allows trending of information, so that the local and state partners can identify areas of concern and implement improvements.

Please see the attached Quality Management Plan, located at the end of this document, for additional information.

S. Suicide Prevention

Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

Provide the most recent copy of your state's suicide prevention plan; or

Describe when your state will create or update your plan.

*States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document *Guidance for State Suicide Prevention Leadership and Plans* available on the SAMHSA website at [here](#).*

The need for stronger coordination and response to suicide prevention led to the development of the NC Suicide Prevention Lifeline. In the United States, one person dies by suicide every 14.2 minutes. In North Carolina, more than 1,000 individuals die from suicide each year and more than 14,000 are treated or hospitalized for self-inflicted wounds. DMH/DD/SAS and the NC Institute of Medicine (NC IOM) collaborated on a suicide prevention plan that addressed the most vulnerable populations among those needing mental health, substance abuse and developmental disability services. The participation of the NC IOM was funded by the Substance Abuse Block Grant and the Community Mental Health Services Block Grant. Developed by a broad-based group that included the North Carolina Mental Health Planning Advisory Council, consumers and others touched by suicide in the state, the Suicide Prevention Plan was released in July 2012 and can be accessed at: <http://www.nciom.org/publications/?suicide>. In addition, a two-page overview is attached.

The recommendations of the plan focus on the roles of DMH/DD/SAS, the Division of Medical Assistance and LME/MCOs in reducing suicide deaths and suicide risk. Among the major elements of the NC IOM Suicide Prevention Plan are the following:

- The NC Suicide Prevention Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week at **1-800-273-8255**.
 - Staffed by trained professionals, the NC Suicide Prevention Lifeline responds to an average of 3000 calls a day. On average, 234 referrals are made directly to the Mobile Crisis Teams, a part of the crisis service array implemented by the LME/MCOs statewide.
 - The NC Suicide Prevention Lifeline is recognized nationally for excellence in the efficiency and volume of its call response.
- Intervention programs
 - Mental Health First Aid (MHFA) is a program that trains the public to identify signs of mental illness and substance abuse and how to respond to them.
 - More than 100 providers have been trained through three regional trainings.
 - Two more training are scheduled before June 2013 in coordination with the Division of Public Health and Community Care of North Carolina (CCNC).
 - Applied Suicide Intervention Skills (ASIST) is a two-day course that trains caregivers on the risk for and signs of imminent suicide and how to prevent it from occurring.
 - As of February 20, 2013, more than seven ASIST gatekeeper trainings had been held in collaboration with the Division of Public Health through the Garrett Lee Smith grant.

- Two more ASIST trainings will be held in the spring of 2013 in collaboration with NC State University through newly acquired Garrett Lee Smith grant funding.

In partnership with the Division of Public Health and with funding from the Garrett Lee Smith Suicide Prevention Grant, a Youth Summit on Prevention of Youth Suicide will be held on May 4, 2013. This summit grew out of an overwhelming response from high schools and students who wanted to participate in a Youth Advisory Council on Suicide Prevention. The number and diversity of youth representing a mix of ethnicities, family cultures, including LGBTQ and military, who initially responded to the announcement have shaped the agenda and focus groups for the day. At least 300 youth will attend this May summit. Information from this summit will help to inform state and local needs assessments and planning that will be done by DMH/DD/SAS, LME/MCOs, local public health departments, local education agencies (LEAs – schools) and community colleges for youth in transition.

The Division's plan has been discussed with the LME/MCO Directors and Medical Directors, the NC MHPAC, and the NC Victim's Assistance Program. It has been disseminated to all System of Care (SOC) Coordinators and Family Partners, the NC Collaborative for Children, Youth and Families, the Commission on Children with Special Health Care Needs, the NC Interagency Coordinating Council for Children with Disabilities and Their Families, the NC Council on Community MH/DD/SA Programs, the NC Pediatric Society School Mental Health Task Force and the NC Child Fatality Task Force. Additional presentations and planning discussions are planned with SOC community collaboratives and other interagency forums in the coming months.

The NC Council of Community Programs, the association of Local Management Entities/Managed Care Organizations, is working with DMH/DD/SAS to draft a standard screening and referral and assessment protocol for suicide prevention as part of the crisis services array through the LME/MCO network statewide.

DMH/DD/SAS, DMA and the LME/MCOs drafted and agreed upon a web-based crisis services plan that will be used uniformly and accessed by providers online in order to ensure that all relevant information is collected and in one place for each consumer, including medical home, suicide prevention plan, Wellness Recovery Action Plan (WRAP) and advance directives, as applicable.

A recent legislative report on Emergency Department admissions and crisis services compiled by DMH/DD/SAS highlighted the need to reduce reliance on ED visits by building a stronger, more consistent and accessible first responder system and increasing access to effective community-based services that can mediate and reduce symptoms before a crisis escalates. It also noted the need for crisis response and a services array that better addresses all ages and ability needs. Although adults are largely represented in such high ED utilization rates, this is also needed for adolescents with severe emotional disturbances who experience crises.

T. Use of Technology

Narrative Question: In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- *What strategies the state has deployed to support recovery in ways that leverage ICT;*
- *What specific application of ICTs the State BG Plans to promote over the next two years;*
- *What incentives the state is planning to put in place to encourage their use;*
- *What support system the State BG Plans to provide to encourage their use;*
- *Whether there are barriers to implementing these strategies and how the State BG Plans to address them;*
- *How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;*
- *How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and*
- *What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.*

States must provide an update of any progress since that time.

In the previous application, the Division reported on the implementation of a Tele-Psych Network Initiative to improve access to and coordination of services in rural and underserved areas of the state. Tele-psychiatry has been approved as a service covered by Medicaid. Ten telepsychiatry pilot projects were funded through grants from the NC DHHS Office of Rural Health and Community Care. Start-up funds were distributed to LME/MCOs and some providers for the purchase of video-conferencing equipment and installation of transmission lines. The pilot sites were expanded and there are currently more than 80 hub and remote sites that provide an array of outpatient services as well as discharge planning and assistance with transition for consumers who are discharged into community-based intervention after hospitalization.

The Division has not developed additional plans for using ICTs to support individual recovery efforts, integrated addiction and primary care services or for program evaluation at the provider level. Prior to considering adoption and promotion of ICTs, the Division would solicit input from various organizations such as the Substance Abuse Federation, local Consumer and Family Advisory Committees, etc. Availability of the devices, perceptions regarding use, projected changes in service outcomes and utilization patterns would be explored with relevant partners.

U. Technical Assistance Needs

Narrative Question: States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to

address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. *What areas of technical assistance is the state currently receiving?*

Please see #2 below.

2. *What are the sources of technical assistance?*

North Carolina is currently receiving technical assistance from SAMHSA's Service Members, Veterans and the Families Technical Assistance Center. The Division, in conjunction with the Governor's Institute, is interested in focusing efforts on assisting military families as more and more service members return to their home communities.

3. *What technical assistance is most needed by state staff?*

The Division had recently requested assistance for surveying the behavioral health system for readiness for trauma-informed care and would appreciate the opportunity to re-visit this. In addition, the Division is interested in receiving technical assistance and guidance regarding moving prevention into the integrated care arena. We are also interested in assistance in preparing the workforce for educating and enrolling individuals in QHPs.

North Carolina also recently requested technical assistance on mental health and school safety, specifically on the Youth version of Mental Health First Aid. We requested consultation on effective and successful strategies for the implementation of this program and other prevention or intervention programs that have been used in other states.

4. *What technical assistance is most needed by behavioral health providers?*

V. Support of State Partners

Narrative Question: The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information exchanges (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.*
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems,*

promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.*
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.*
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.*

The Division relies heavily on strategic partnerships within the NC Department of Health and Human Services (DHHS), with other state government agencies and the State university system, as well as local government entities, advocacy organizations, consumer organizations, professional organizations and other stakeholder groups.

Specifically, the Division works collaboratively with other divisions and offices of the NC DHHS, including:

- State Operated Healthcare Facilities
- The Division of Vocational Rehabilitation
- The Division of Public Health
- The Division of Aging and Adult Services
- The Division of Services for the Blind
- The Division of Services for the Deaf and Hard of Hearing
- The Division of Child Development
- The Division of Health Services Regulation
- The Division of Medical Assistance
- The Office of Rural Health and Community Care
- The Division of Social Services
- Office of Medicaid Management Information Systems

The largest initiatives in which DMH/DD/SAS is currently involved include the statewide implementation of the 1915 (b)/(c) Medicaid Waiver and integration of behavioral health and physical health care. These result in particularly close working relationships between every section of the Division and the Division of Medical Assistance and the Office of Rural Health and Community Care with its Community Care of North Carolina. In addition, the Division partners with the Division of Public Health for HIV/Early Intervention Services across the state. University-system partners include NC State University in their management of the NC TOPPS infrastructure and data collection, as well as numerous projects with the University of North Carolina's Behavioral Healthcare Research Program under the School of Social Work.

The Division's Justice Systems Team is a best practice team responsible for addressing policies and practices regarding adult and child mental health, developmental disabilities and substance abuse needs relative to criminal and juvenile justice systems, including Drug Control and Driving While Impaired Services. The team provides leadership regarding evidence-based, best and promising practices related to services and supports for individuals, systems performance, and multi-system coordination. Collaboration occurs with law enforcement (federal, state, county and local) and community and institutional corrections systems (detention centers, youth development centers, jails, prisons, adult and juvenile courts, probation, parole and post-release supervision). Activities are intended to inform and operationalize public policy, identify areas of need, test models and strategically plan with other agencies, such as:

- Department of Public Safety (DPS)
 - Division of Community Corrections (DCC)
 - Division of Alcoholism and Chemical Dependency Programs (DACDP)
- Division of Prisons (DOP)
- Administrative Office of the Courts (AOC)
- Department of Juvenile Justice and Delinquency Prevention (DJJDP)
- Governor's Crime Commission (GCC)
- Division of Motor Vehicles (DMV)
- Office of the Attorney General
- State Bureau of Investigation (SBI)
- Drug Enforcement Agency (DEA)
- Local Law Enforcement Agencies
- Sheriffs' Association

W. State Behavioral Health Advisory Council

Narrative Question: Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. SAMHSA encourages states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

What planning mechanism does the state use to plan and implement substance abuse services? How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services? Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council? Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Please describe the duties and responsibilities of the Council.

The State has chosen to use the established North Carolina Substance Abuse Federation to continue providing advice, consultation and recommendations for the Substance Abuse Prevention and Treatment Block Grant and review activities and services.

The North Carolina Substance Abuse Federation is a statewide group of individuals and organizations working in partnership to protect the rights of North Carolinians living with the disease of addiction and co-occurring mental illness with the mission to promote policies to assure quality systems of education, prevention and the expansion of a continuum of treatment services to effectively meet the needs of the substance abuse population.

The Federation by-laws state membership in the North Carolina Substance Abuse Federation is “open to designated representatives of groups and organizations that identify with the mission.” The by-laws therefore recognize two membership categories: Organizations and Groups. Organizations are defined as entities incorporated to benefit its dues paying members. Groups are incorporated or unincorporated entities organized to advocate and or advise.

Behavioral Health Advisory Council Members – Table

LIST OF NORTH CAROLINA SUBSTANCE ABUSE FEDERATION MEMBERS

Name	City	Agency or Organization Represented	Email Address if available
Kurtis Taylor, Chairperson	Raleigh	Oxford Houses of North Carolina	Kurtis.taylor@oxfordhouse.org
Angie Banther, Vice Chairperson	Lexington	Piedmont Area Substance Abuse Providers Association	abanther@apathofhope.org
Jessica Herrmann, Secretary	Raleigh	North Carolina Substance Abuse Providers Association	Jessica.herrmann@governorsinstitute.org
Phil Mooring	Wilson	North Carolina Substance Abuse Prevention Providers Association	phil@familiesinaction.org
Tim Hall	Fayetteville	Women’s Treatment Provider Collaborative & External Advisory Team SA Representative	gt_hall@rhcc1.com
Clarissa Goodlett, Secretary	Raleigh	Governor’s Institute on Drug Abuse Legislative Liaison	cgoodlett@gmail.com
Wrenn Rivenbark	Raleigh	Addiction Professionals of North Carolina	rwg08@doc.state.nc.us
Trish Hussey	Chapel Hill	Addiction Professionals of North Carolina	director@freedomhouserecovery.org

Name	City	Agency or Organization Represented	Email Address if available
Debbie Fike	Fayetteville	Addiction Professionals of North Carolina	zbeagledog@embarqmail.com
Anne Doolen	Salemburg	Alcohol and Drug Council of NC	adoolen@alcoholdrughelp.org
Jaci Betts	Asheboro	Employee Assistance Professionals Association	jacib@fhahelps.com
David Turpin	Raleigh	North Carolina Affiliated Substance Abuse Providers Association	dctur@aol.com
Jason Shirtz	Greenville	North Carolina Affiliated Substance Abuse Providers Association	jshirtz@porthumanservices.org
Kay Paksoy	Raleigh	National Association of Social Workers – NC Chapter	kay@naswnc.org
Deeanna Hale Holland	Wilmington	North Carolina Substance Abuse Prevention Providers Association	deeanna@coastalhorizons.org
Robin Huffman	Burlington	North Carolina Psychiatric Association	rhuffman@ncpsychiatry.org
Tad Clodfelter	Raleigh	North Carolina Psychological Association	ClodfelterT@southlight.org
Sally Cameron	Cary	North Carolina Psychological Association	sally@ncpsychology.org
Wes Stewart	New Bern	North Carolina TASC	wstewart@nctasc.net
Karen Chapple	Wilmington	North Carolina TASC	kchapple@coastalhorizons.org
Leslie Goubran	Charlotte	Adolescent Provider Collaborative	leslie.mitchell@mcleodcenter.com
Eric Davis	Greensboro	Adolescent Provider Collaborative	edavis@youthfocus.org
Tony Beatty	Charlotte	Alcohol and Drug Abuse Providers and Professional Association	Tony.Beatty@MecklenburgCountyNC.gov
Kim Anthony-Byng	Charlotte	Alcohol and Drug Abuse Providers and Professional Association	kim.anthony-bying@anuvia.org
Dorsey Ward	Charlotte	Alcohol and Drug Abuse Providers and Professional Association	Dorsey.ward@carolinashealthcare.org
Connie Mele	Charlotte	Alcohol and Drug Abuse Providers and Professional Association	Connie.Mele@mecklenburgcountync.gov
Kathleen Gibson	Garner	Oxford Houses of North Carolina	Kathleen.gibson@oxfordhouse.org
Jimmy Cioe	Chapel Hill	Cardinal Innovations	jimmy.cioe@cardinalinnovations.org
Donna Cotter	Chatham County	RecoveryNC	dcotter@nc.rr.com
Karen McLeod	Raleigh	Benchmarks	kmcleod@benchmarksnc.org

Name	City	Agency or Organization Represented	Email Address if available
Ty Dexter	Durham	Therapeutic Communities Association	tdexter@trosainc.org
Joseph Martinez	Black Mountain	Therapeutic Communities Association	josephm@firstinc.org
Hendree Jones	Chapel Hill	Women's Treatment Provider Collaborative	hendree_jones@med.unc.edu
Margaret Stargell	Wilmington	External Advisory Team SA Representative	stargell@coastalhorizons.org
Thomas Savidge	Onslow County	External Advisory Team SA Representative	tsavidge@porthumanservices.org
Mary Edwards	Raleigh	Division of Aging and Adult Services	Mary.edwards@dhhs.nc.gov
Gina Price	Raleigh	Division of Vocational Rehabilitation	Gina.price@dhhs.nc.gov
Lee Lewis	Raleigh	Division of Mental Health, Developmental Disabilities and Substance Abuse Services	Lee.lewis@dhhs.nc.gov
Flo Stein	Raleigh	Single State Agency	Flo.Stein@dhhs.nc.gov

Behavioral Health Council Composition by Member Type – Table

NORTH CAROLINA SUBSTANCE ABUSE FEDERATION COMPOSITION BY TYPE OF MEMBER

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	39	100%
Individuals in Recovery	7**	18%**
Family Members of Individuals in Recovery	12	31%
Vacancies (Individual and Family members)	2	5%
Others (Not state employees or providers)	8	21%
TOTAL Individuals in Recovery, Family Members & Others	9	23%
State Employees	4	10%
Providers	22	56%
Leading State Experts	4	10%
Federally Recognized Tribe Representatives	0	0%
Vacancies	1	3%
TOTAL State Employees, Providers & Leading Experts	30	77%

**of those that have self-disclosed that they are in recovery.

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question: Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it

intends to utilize the three percent to impact enrollment and business practices, taking into account the identified needs, including:

- *Outreach and enrollment support for individuals in need of behavioral health services.*
- *Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.*
- *Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.*
- *Third-party contract negotiation.*
- *Coordination of benefits among multiple funding sources.*
- *Adoption of health information technology that meets meaningful use standards.*

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has contracted with the Governor's Institute on Substance Abuse for a number of years with SABG funds. The Governor's Institute began as a task force in 1986, was officially incorporated as a 501(c)(3) non-profit corporation in 1990 and is an important partner and resource for the community and state.

An integral component of the work of the Governor's Institute is to provide, facilitate and arrange for training for providers of addiction services, as well as LME/MCOS. As stated earlier, at this time, North Carolina has decided not to expand Medicaid coverage for adults and not set up a health insurance exchange, but will offer plans through the federal exchange. However, over the past year, the Governor's Institute has provided numerous trainings on topics relevant to the Affordable Care Act and MHPAEA, including contract negotiation, contract content and expectations, third party billing, etc. North Carolina's behavioral health system has operated under a fee-for-service structure for a number of years; therefore, many providers and LME/MCOs are familiar with business and managed care concepts. However, the Governor's Institute has focused on trainings of this nature to improve the viability of the system. Plans for this fiscal year include the above mentioned topics, as well as additional areas such as outreach and enrollment of individuals eligible for Medicaid, working with the North Carolina Department of Insurance regarding plans offered through the federal exchange, bundled rates, billing for dually eligible individuals, the 1115 waiver, electronic health records and recovery oriented system of care.

In addition, North Carolina is working with Enroll America to educate individuals regarding their eligibility for services. At this time, the state is seeking partnerships with the LME/MCOs and others to solicit Navigators and educate potential consumers. The Division has encouraged a number of substance abuse and mental health advocacy organizations to apply for funds to become navigators.

Y. Comment on the State BG Plan

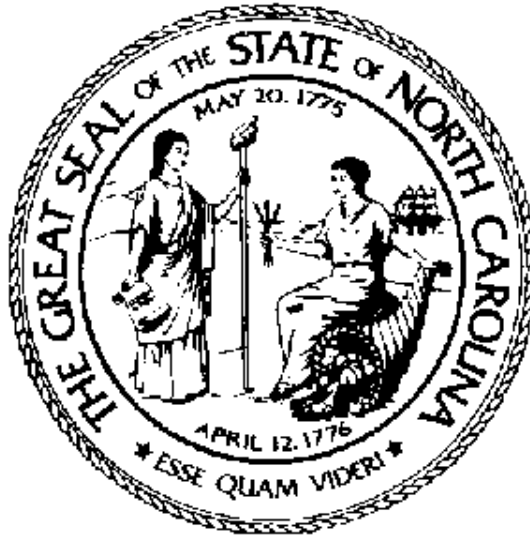
Narrative Question: Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Portions of the SABG were presented and discussed with members of the Substance Abuse Federation during their regularly scheduled meetings. Comments received to date include:

- Everyone espouses the importance of best practices, but implementing them with fidelity to the model is hard to do when consumers aren't given enough time in treatment to reap the benefits of the model.
- The issue of residential treatment. The people we see will never make it to outpatient. They need to be off the streets.
- MAT- how are we supposed to utilize medications when they are so expensive and our clients can't afford them once they leave.
- Housing- we can have the best programs in the world but if the person does not have a safe place to sleep and food in their belly they are not going to be able to remain clean and sober. While the Oxford House model is good for many, it does not meet the needs of everyone. We need some sober living facilities where the residents don't have to have money up front or maybe at all.

Comments will continue to be discussed with and solicited from the Federation. In addition, once approved by the Secretary of NC DHHS, the 2014-2015 SABG Behavioral Health Assessment and Plan will be posted on the Division's website with instructions for public comment.

North Carolina Department of Health and Human Services



Service System Integrity Plan SFY: 2012-2013

for

The Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

Revised: June 18, 2013

Purpose

It is the purpose of the Service System Integrity Plan to ensure compliance, efficiency and accountability within NC DMH/DD/SAS programs by detecting and preventing fraud, waste, program abuse, and by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with laws and regulations, and in support of programmatic goals.

Guiding Principles

This Service System Integrity Plan will promote the following principles:

1. Ensure the most cost efficient behavioral health care system possible while supporting a quality service delivery system.
2. Support LME/MCOs in carrying out effective Service System Integrity efforts.
3. Hold LME/MCOs accountable when their systems fail to prevent improper billing by fully utilizing available administrative tools (payment suspension, prepayment review, audit and sanctions) when improper payments are discovered.
4. Proactively recognize areas of vulnerability that may adversely affect Service System Integrity and communicate these vulnerabilities to management.

Responsible Staff

Chief of Resource and Regulatory Management – responsible for ensuring the Service System Integrity Plan for State and Block Grant funds is carried out.

Chief of Community Policy Management – responsible for programmatic leadership and policies regarding utilization of State and Block Grant funds.

Financial Operations Team Leader and designees – responsible for budget management of State and Block Grant funds and supervision of staff that conduct the State and Federal NonUCR Settlement, performing audits of financial status reports submitted by non-profits; chairing the Center of Excellence contract review committee.

Accountability Team Leader and designees – responsible for monitoring/auditing LME/MCOs for compliance with State and Federal Block Grant rules and regulations; development of the DMH/DD/SAS subrecipient monitoring plan and oversight of its implementation.

Quality Management Team – responsible for developing and monitoring performance measures and communicating areas of concern to designated teams and management.

Block Grant Coordinators – responsible for keeping abreast of Block Grant regulations and requirements, communication with DHHS staff and LME/MCOs and coordination of planning goals and strategies relevant to the Block Grant within DMH/DD/SAS.

LME Team – responsible for administering the performance contract with LME/MCOs and monitoring LME/MCO compliance with the terms of the contract.

Plan

1) **Budget Review**

- a) The NC DMH/DD/SAS contracts with the LME/MCOs to administer and oversee State and Block Grant funds for the provision of prevention and treatment services.
 - i) State and Block Grant prevention and treatment funds are allocated to LME/MCOs annually through a Continuation Allocation letter and all revisions are tracked through the Allocation Letter process.
 - ii) Block Grant funds are allocated by Federal Fiscal year and subcategory of the Block Grant (e.g., SAPTBG Women's Set Aside). The accounts are also separate for Unit Cost Reimbursement (UCR) and expenditure based (NonUCR) subcontracting. Financial Operations ensures that Block Grant funds allocated to LME/MCOs are within expected Federal allocation levels, and revises LME/MCO allocations to reflect changes in Federal allocations as necessary. If the LME/MCO wants to request a transfer of Federal funds from one account to another, the LME/MCO must make that request in writing and justify the request. It is reviewed by Community Policy Management for compliance with funding regulations and Block Grant Plan goals, by Financial Operations for fund availability, by DHHS Budget and Analysis and approved by OSBM.
- b) **Direct contracts** that utilize Block Grant funds are managed by Program Managers in the Community Policy Management section of NC DMH/DD/SAS. The Program Managers ensure that the subcontractors fulfill requirements of the Federal government and the approved application for Federal funds (NC Block Grant Assessment and Plan). These contracts are reimbursed on an expenditure basis within a contract maximum and are monitored by the contract managers according to Subrecipient Monitoring procedures. The Resource and Regulatory Management Section, Accountability Team tracks the subrecipient monitoring completed by contract managers to assure compliance with the requirements of the Federal Office of Management and Budget and the requirements set within the contracts. The Accountability Team reports on the findings as required to the Controller's office or State auditor. An example of a direct contract includes the Alcohol and Drug Council, which receives SA prevention and treatment funds.
- c) Financial Operations manages the **administrative** portion of Federal Block Grant funds through specified revenue codes in the State budget for NC DMH/DD/SAS. The annual Cost Allocation Plan determines which administrative expenses are allocated to Federal grants. Financial Operations works with CPM to ensure correct methodology is utilized. Financial Operations staff ensure that expenditures are restricted to budgetary limits throughout the fiscal year.

2) **Claims Payment and Adjudication**

- a) For Block Grant and State funded UCR services, claims are adjudicated locally by the LME/MCO, and then passed to the State's claims vendor for a second adjudication. The LME/MCOs have a choice of paying the service provider based on their local adjudication or waiting until the State level adjudication occurs. LME/MCOs have adjudication audits/edits in place to ensure at a minimum: the provider has a valid contract, the service is not duplicated, the fields contain valid values, the service was authorized by the LME/MCO and the rate is at or below the contract maximum for that service.

- b) The State claims system adjudication includes similar audits and edits. The State claims vendor also adjudicates for diagnostic match with the procedure code and the Target Population eligibility, as well as compliance with other service definition requirements, such as same day exclusions for certain procedure codes. The LME/MCO must also designate in the State's claims adjudication system which of their subcontractors are eligible to earn Federal Block Grant funds. This edit was implemented in FY13.
- c) Budget Criteria are established annually and published on the NC DMH/DD/SAS website that designates the criteria for payment from each Federal Block Grant account. For example, certain accounts are limited to specific clinical Target Populations and procedure codes. Target Populations are specific to Block Grant funding categories, such as "Injecting Drug User/Communicable Disease Risk" and "Adult Substance Abuse Women". Services that meet the Budget Criteria, but are adjudicated after the LME/MCO has pulled down their Federal allocation, count toward justification for the State funds allocation.
- d) Periodically, a transfer or adjustment between accounts or grant award periods occurs after the claim was first adjudicated. These adjustments are not tracked at the claims level in the current claims adjudication system, but procedures for account adjustments will be developed in the new claims adjudication system being implemented in July 2013.

3) Expenditure Report Analysis

- a) NonUCR Block Grant funds are managed by the LME/MCOs. They subcontract with providers who carry out the Block Grant treatment and prevention goals required by the Federal government and specified in the approved NC Block Grant Assessment and Plan. Each LME/MCO is responsible for monitoring NonUCR Block Grant expenditures throughout the fiscal year, both fiscally and programmatically. The NC DMH/DD/SAS Block Grant Steering Committee reviews the NonUCR Expenditure Overview report, which summarizes expenditures by LME and Account, monthly for overall and LME/MCO specific earnings year-to-date relative to budgets.
- b) UCR Block Grant expenditures are monitored monthly by the NC DMH/DD/SAS Block Grant Steering Committee. The committee reviews a summary report which shows YTD expenditures by Block Grant UCR account. This report displays the earnings relative to the budget for each LME/MCO and for each account as a whole. The Committee is able to identify earnings issues and recommend transfers of funds as appropriate. Within each LME/MCO, it is expected that Block Grant earnings are monitored on at least a monthly basis, and remedial actions are taken at the local level to ensure funds are drawn down appropriately throughout the fiscal year.
- c) Expenditures of state funds (UCR and NonUCR) are monitored at the LME/MCO and Disability levels to ensure stability of the service system and maintenance of effort.

4) Compliance Reviews

- a) Substance Abuse Block Grant prevention and treatment services and Mental Health Block Grant services are monitored through LMEs, Program and Individual monitoring annually by the Resource and Regulatory Management Section, Accountability Team. The monitoring tools are posted on the NC DMH/DD/SAS website and are specific to the category of funds; i.e., prevention, Women's Set-Aside, IV Drug Users, etc. A sample of providers and individuals whose services were reimbursed with Federal Block Grant funds is selected from claims

reimbursed with Federal Block Grant funds. The Accountability Team produces a monitoring report for each LME/MCO. In accordance with the NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plan(s) of Correction, if systemic compliance issues are found, a plan of correction is required. LME/MCOs have 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS. Additionally, within 60 days after the approval of the plan of correction, the Accountability Team will review the plan of correction and determine if the plan was appropriately implemented.

- b) Semi-Annual Compliance Reports are submitted by each LME/MCO. These Compliance Reports serve as a mechanism to ensure that the LME/MCOs are adhering to the broad categorical requirements of the Block Grant; i.e., assuring priority admission for specific populations, providing outreach services for certain populations, as well as reporting specific prevention activities. These reports are reviewed by Block Grant Coordinators and programmatic managers of the Community Policy Management Section for accuracy and content and feedback is provided to the LME/MCOs.
- c) Independent Peer Review (IPR) is conducted annually by a third party under contract with the DMH/DD/SAS for the treatment component of the Block Grant. Specific services are selected each fiscal year for review and a 5% sample of those programs is chosen. The goal is to have a representative sample of providers, across all regions of the state that work with a diversity of consumers in a variety of settings. Criteria for selection includes: (1) total amount of UCR funds paid during the fiscal year; (2) location/region; (3) size; (4) service areas; (5) availability for review. Reviewers are volunteers, but selected based on clinical experience and expertise in the service area being reviewed, appropriate certifications/licensure, cultural sensitivity, interest in the process and completion of the IPR training. Individual reports are completed and submitted to NC DMH/DD/SAS, as well as the agencies reviewed. In addition, feedback surveys are completed by the reviewers, as well as the participating sites.
- d) The Financial Operations Team ensures that the LME/MCOs are meeting the FFATA reporting requirements per the Federal Funding Accountability and Transparency Act. This information is required as a part of the financial section within the Local Management Entity/Managed Care Organization (LME/MCO) operational contract with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.
- e) The Accountability Team has the lead role in the Department for the standardization of local monitoring to be completed by the LME/MCOs. Gold Star is the monitoring process employed by the former PBH LME/MCO (the original NC managed care organization). The Accountability Team lead the revisions and updates to the application and routine monitoring sections of the Gold Star process, encompassing other successful monitoring procedures and creating a standardized process that is implemented statewide. Additional modifications are in process to include the higher levels attainable by providers within the Gold Star process. Data will be gathered by DMH/DD/SAS and analyzed related to statewide trends, findings and ongoing development of the system.

5) Utilization/Performance Analysis

- a) The Quality Management Team tracks and monitors LME/MCO system performance through a set of indicators in the Community Systems Progress Report. A number of these indicators are

based on nationally recognized behavioral health measures. When an LME/MCO is found to be performing below standards on performance measures, the LME/MCO Monitoring and Technical Assistance Procedure is followed to improve the performance of the LME/MCO.

- b) The Clinical Quality Subcommittee reviews identified outliers and significant service trends to determine if there is concern that service delivery might be out of compliance with the service definition, rules or statutes. Where appropriate, these outliers, trends or compliance concerns are monitored according to the Targeted Services Monitoring Procedure by the Accountability Team. In cases where the utilization of Federal Block Grant funds is determined to be out of compliance and a payback required, those funds are utilized for other appropriate services if there is sufficient time within the Block Grant allocation period. If the period has ended, Financial Operations refunds the funds to the Federal government.

6) **Audits**

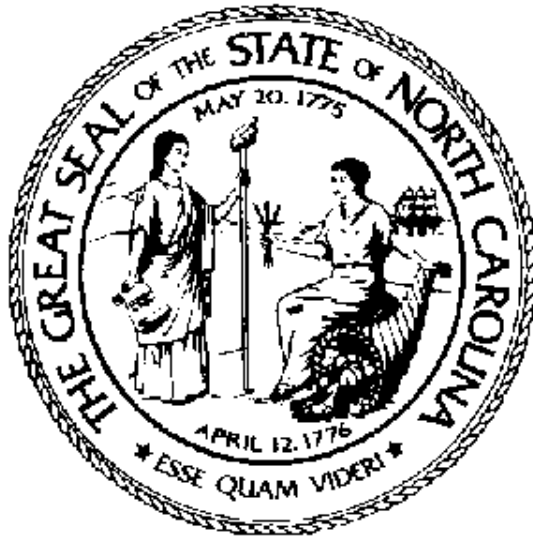
- a) Each LME/MCO's Systems Administration Funds, Single Stream service funds and NonUCR expenditures are audited annually by the audit group in the Financial Operations Team (see procedures Preparation of Tentative Settlement Report and LME/MCO Settlement Guidelines). These procedures ensure that fiscal operations related to the LME/MCO service delivery and system management are being documented and reported accurately. If the LME/MCO is found to be out of compliance and a payback is required, funds that are received are processed according to State policy.
- b) The Office of the State Auditor audits the NC DMH/DD/SAS' monitoring procedures for the Federal Block Grants on an annual basis for compliance with federal regulations. Findings and recommendations are issued as indicated, and the Division responds with a plan of correction.

- 7) ***The state ensures that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered*** in two ways. For NonUCR (expenditure based allocations) the LME/MCOs are responsible for local management of the funds. The LME/MCO designates a staff person to oversee the Federal CMHBG and SAPTBG funds, who oversees program development, budgets, contracts and reimbursement. The NonUCR Settlement process ensures that Federal regulations are followed. For Unit Cost Reimbursed (UCR) services, the payment rates are standard across the state, with exceptions only when justified and approved by the state.
- 8) ***The state assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards*** through a combination of training, monitoring and independent peer review (as noted in number 4 above). The Compliance Reviews by the Accountability Team include plans of correction that address exceptions with the required program elements. Included are elements that relate to consumer safety, such as TB testing and HIV/Early Intervention services. Each LME/MCO has staff designated as the Substance Abuse Point of Contact for their agency. Monthly conference calls are conducted with the SA Points of Contact and various DMH/DD/SAS staff to provide technical assistance, updates and trainings on specific or requested topics. Compliance checks are also conducted by CPM staff. For example, Prevention and Early Intervention team staff conduct site visits to review for fidelity to best practices for Project T&D and

All Stars. CPM staff also provide training at conferences such as the Summer and Winter Schools for Alcohol and Drug Studies.

- 9) ***The state will ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid.*** The Federal Block Grant claims adjudication system periodically re-adjudicates claims taking into account retro-active Medicaid, and reverses payments made with Block Grant funds when Medicaid coverage is determined. Additionally, as a part of the audit of LME/MCO NonUCR expenditures, the audit team checks to ensure services reimbursed on an expenditure basis are not also reimbursed through the claims system. Starting in FY13, the state will monitor to ensure that LME/MCOs include State/Block Grant services in their Coordination of Benefit (COB) Policies and Procedures and are sampling State/Block Grant services when they monitor Providers. This will occur as a part of the annual IMT reviews in conjunction with DMA, as there is a parallel requirement regarding Medicaid funded services.

North Carolina Department of Health and Human Services



Quality Management Plan SFY: 2013-2014

for

The Division of Mental Health, Developmental Disabilities
And Substance Abuse Services

Revised: June 13, 2013

Introduction

The [North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services](#) (DMH/DD/SAS) Quality Management Plan outlines the Division's Quality Management Program, its values and guiding principles, approach, structure, responsibilities, and improvement initiatives.

Quality Management is an all-encompassing philosophy at DMH/DD/SAS that is dedicated to excellence, is customer-focused, and values and involves all DMH/DD/SAS employees, stakeholders, partners, and customers. Quality Management makes everyone responsible for quality and customer satisfaction and empowers each person to contribute to its achievement. The values and guiding principles of Quality Management are integrated throughout the organization's structure, business processes, daily work activities, job responsibilities, communications, interactions, and work products in a concerted effort to achieve desired outcomes.

Quality Management embraces features of both Quality Assurance and Quality Improvement and goes one step further to direct the management philosophy. While these definitions below serve to differentiate the three terms, it is the values of these three definitions that guide or Quality Management program.

Quality Assurance (QA) is a systematic, departmental approach to ensuring a specified standard or level of care. Traditionally, it has focused on a few individuals detecting and solving "special" problems. It uses methods to inspect performance, and repair or correct performance if it is below an accepted standard. The emphasis is on identifying outliers and taking steps to bring their performance in line with the norm.

Quality Improvement (QI) is a systematic, organization-wide approach for improving the overall quality of care - one that emphasizes performance improvement as well as a standard of care. It differs from QA in its scope, focus, approach and end result. The scope is organization-wide rather than in select departments. The focus is on identifying common causes and on processes, rather than on outliers and clinical outcomes. The approach is proactive rather than reactive. And the end result of QI is to prevent errors and to improve rather than to inspect and repair problems.

Quality Management (QM) is an all-encompassing philosophy that permeates an organization's management infrastructure, policies and practices. It typically consists of five basic principles -- a focus on customer/supplier relationships; an emphasis on operational and care systems and the prevention of errors; the use of data-driven decision making; the active involvement of leaders and empowerment of employees; and, an emphasis on continuously improving performance in all areas.

Values and Guiding Principles of the Quality Management Program

The DMH/DD/SAS Quality Management Plan weaves together the mission and vision of the NC Department of Health and Human Services and DMH/DD/SAS with the guiding principles of the DHHS Excels initiative, a Total Quality Management philosophy, the National Behavioral Health Quality Framework, and the federal Centers for Medicare and Medicaid Services Quality Framework to formulate a structure and a process to achieving a high quality MH/DD/SA service system.

The mission of the [NC Department of Health and Human Services](#) (NC DHHS) is, ***in collaboration with its partners, to protect the health and safety of all North Carolinians and to provide essential services.*** This mission is driven by a vision that all ***North Carolinians will enjoy optimal health and well-being.***

It is the mission of NC DMH/DD/SAS that, ***North Carolina will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

In 2009 NC DHHS launched [DHHS Excels](#), a management and organizational vision to ensure better quality of care, customer service, efficiency and responsibility through being:

- ❖ **Customer service focused.** North Carolinians are the center of our service design and delivery, and allocation of human and fiscal resources.
- ❖ **Anticipatory.** DHHS actively monitors changes in the needs of its customers and the impact of its services and applies new and innovative approaches in a timely, targeted and effective manner.
- ❖ **Collaborative.** DHHS values internal and external partnerships.
- ❖ **Transparent.** DHHS shares information, planning and decision-making processes and communicates openly with its customers and partners.
- ❖ **Results-oriented.** DHHS emphasizes accountability and measures its work by the highest standards.

The NC DMH/DD/SAS Quality Management plan incorporates the missions of DHHS and DMH/DD/SAS, promotes the values of DHHS Excels and focuses on priority areas that have the greatest potential to improve services, inform stakeholders and develop outcome focused measures.

Quality Management Program Approach

NC DMH/DD/SAS long-term quality management success will be achieved through a Total Quality Management (TQM) approach that promotes a customer-focused atmosphere that involves all employees in continual improvement efforts. Our customers include persons receiving services and their families, our funders, all DHHS divisions, Local Management Entities/Managed Care Organizations (LME/MCOs) and their provider networks, State and local Consumer and Family Advisory Committees (CFACs) and other state and local stakeholders. To achieve a culture of quality requires DMH/DD/SAS to effectively communicate and champion service delivery and project improvement initiatives.

To be effective, quality management requires integrated structures and processes that permeate all levels of every organization within the service system and works toward the objectives of:

- ❖ **Safeguarding** the health, safety and rights of persons served
- ❖ **Improving customer services** through collaboration with or input from persons served and their families
- ❖ Ensuring **fair and easy access** to services
- ❖ Supporting the achievement of desired **outcomes and satisfaction** for persons served
- ❖ Ensuring the **integrity, effectiveness and continuous improvement** of services through review of consistent and credible data
- ❖ Ensuring **compliance** and guiding improvements of the services provided under state and federal funding and Medicaid waivers
- ❖ **Cultural competence**
- ❖ **Collaboration with other agencies**

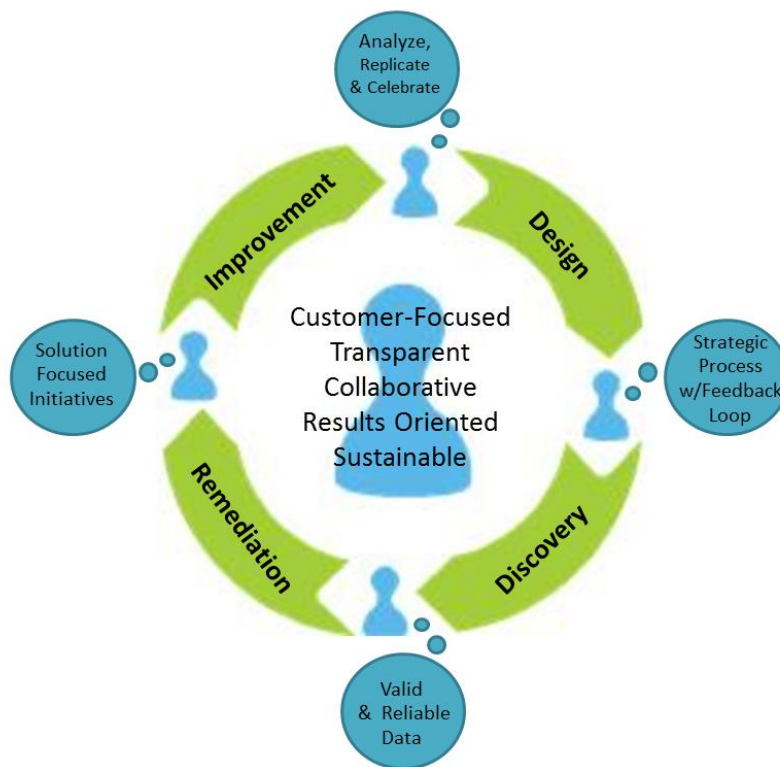
TQM will be achieved through implementing a culture, approach and agency structure that provides a collaborative approach to enable persons served to live successfully in their communities.

Quality Management Infrastructure

The DMH/DD/SAS Quality Management (QM) structure provides a mechanism for ongoing attention to the clinical quality and effectiveness of the service system. This structure, coordinated by the DMH/DD/SAS Quality Management Steering Committee with oversight by the DMH/DD/SAS Executive Leadership Team, brings together staff from across DMH/DD/SAS to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds. It links to partner DHHS agencies to address the cross-agency goals and responsibilities of the 1915 b/c Medicaid Waiver and of the DHHS Excels initiative, as well as other departmental responsibilities that cross division boundaries.

Quality Framework

The federal Centers for Medicare and Medicaid Services promote a comprehensive framework for managing waiver plans. DMH/DD/SAS has adopted and promoted this framework since 2003; it consists of four distinct, but related, activities that form a continuous, interdependent process. The framework is applied to clinical and performance outcome measures to assist with communicating and monitoring quality improvement initiatives.



Design: The design function refers to strategies for building quality assurance and quality improvement into the conception and design of the system. It includes mechanisms such as effective information systems, communication channels, feedback loops.

Discovery: The discovery function refers to the collection, analysis and reporting of information to make certain that people, processes and products are meeting basic requirements of quality and to evaluating progress toward goals. It includes compliance monitoring and audit activities, collection and analysis of trend data on services, consumer perceptions and outcomes, recurring management reports and dashboards and targeted evaluation studies.

Remediation: Remediation refers to strategies used to identify, analyze and correct problems quickly and effectively. Mechanisms vary based on the situation and can include consultation and technical assistance, training, development of new initiatives, plans of correction, repayment of funds, loss of certification and redirection of resources.

Improvement: Improvement refers to systematic strategies to make incremental enhancements to operations and procedures that move the system toward achieving specified goals.

Involvement of Stakeholders

The QM Steering Committee will determine ways to involve representatives from CFACs, LME/MCOs, provider agencies and other stakeholders. The DMH/DD/SAS will actively seek and integrate consumer and family representation in workgroups and taskforces that are making policy recommendations. It will also continue to ensure regular communication and feedback through communication bulletins, websites, forums, trainings and conference participation.

External Linkages

The QM Steering Committee will ensure coordination with standing advisory and stakeholder committees with responsibilities for quality of the service system including:

- ❖ DMH/DD/SAS External Advisory Team
- ❖ State Consumer & Family Advisory Committee
- ❖ DHHS LME-MCO Director Meetings
- ❖ DHHS LME-MCO Quality Management Meetings
- ❖ LME-MCO Quality Improvement Forum
- ❖ Block Grant Planning Council
- ❖ Departmental Waiver Advisory Committee
- ❖ DHHS Excels Goals Committee
- ❖ Service Advocacy Organizations

The Executive Leadership Team and QM Steering Committee will foster collaborative efforts with DMA to ensure coordinated oversight of the 1915 b/c Medicaid Waiver and the DMA Quality Strategy for the North Carolina Behavioral Health Prepaid Inpatient Healthcare Plans.

Building a Quality Culture into Daily Work at DMH/DD/SAS

In 2009, NC DHHS implemented DHHS Excels, a management and cultural transformation designed to provide a collaborative, accountable and results-based organization. DHHS Excels embraces the values of transparency, being results oriented, pro-active, collaborative and customer-focused, all which are essential elements of Quality Management. DHHS Excels created a workforce development model that included:

- ❖ Quality Improvement as part of job descriptions, employee training and evaluation
- ❖ Standards for internal customer service
- ❖ A Code for Ethical Conduct for staff
- ❖ Guidelines designed to promote teamwork
- ❖ Focus on establishing an effective work culture in the midst of change

The Mission, Vision and Values of DHHS Excels are championed at DMH/DD/SAS by the Executive Leadership Team to promote comprehensive, sustainable and outcome focused initiatives.

Ongoing Performance Measurement & Sustainability

Regular feedback over time is a key to ensuring and sustaining improvements in quality. Regular monitoring against performance targets or standards provides information on how the system is doing. It helps identify areas of excellence, opportunities for improvement, and potential problems. Once an opportunity for improvement or potential problem area has been identified, studied and action has been taken to make an improvement, regular monitoring is needed to ensure that the action taken was effective and achieved the desired level of improvement.

If the desired level of improvement did not occur, additional action or a different course of action may be needed to achieve it. If the desired level of improvement did occur, regular monitoring is again needed to make certain that the improvement is sustained.

Regular periodic monitoring of key indicators will help assure that the system is working as intended, opportunities for improvement area identified and acted upon, and desired improvements are achieved and sustained and that successful practices become ingrained and do not fade away, as attention shifts to other priorities. A process for periodic monitoring of key indicators is established by the Quality Management Steering Committee. Monitoring of indicators will include:

- ❖ Reviewing valid and reliable performance and outcome data
- ❖ Determining significance of trends and patterns
- ❖ Implementing improvement initiatives
- ❖ Evaluating improvement initiatives
- ❖ Raising the bar on measures when appropriate
- ❖ Evaluating and revising the QM plan

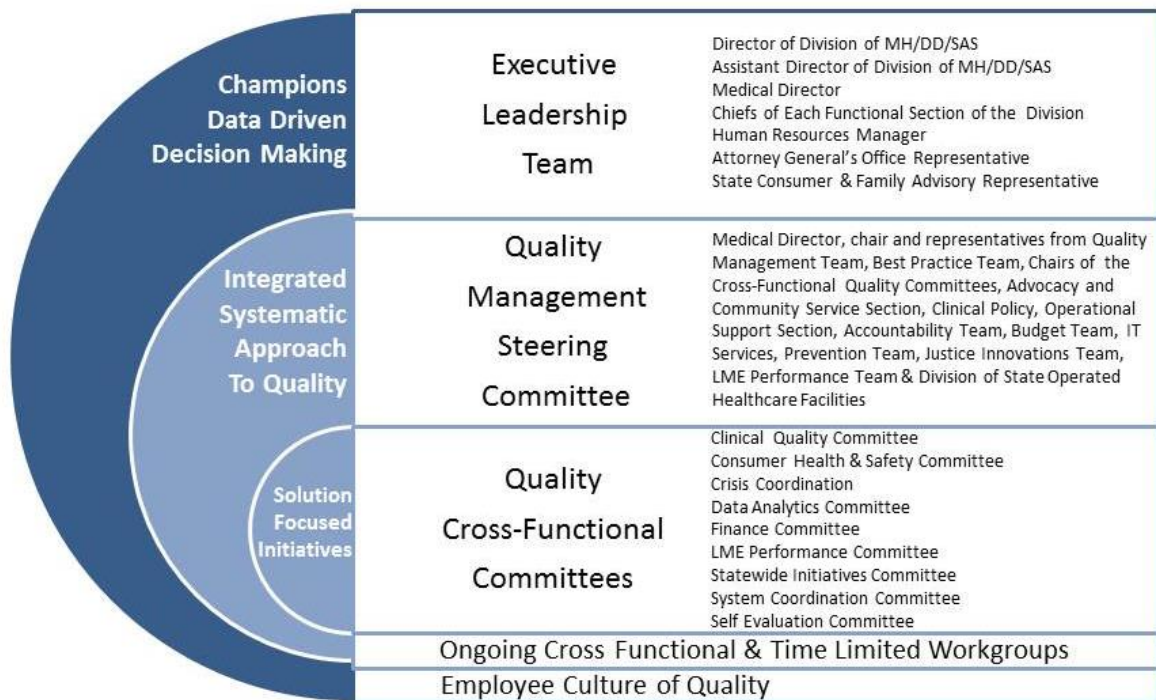
Communication and Replication of Success

Communication is critical to the success of any quality improvement effort. The Executive Leadership Team will communicate the priorities, a directional vision and goals, and will be apprised of initiatives and quality improvement projects as related to the priorities and goals. Division leadership will support a culture conducive to open communication, information sharing and champion data driven decision making.

Communication will occur throughout the quality improvement process using the Centers for Medicare and Medicaid Services Quality Framework to promote strategic and solution focused initiatives. The QM Cross-Functional Committees will routinely report to the Quality Management Steering Committee on improvement initiative status. Reports will be based on consistent and credible data and will be examined to determine if changes have produced the desired results, or if further adjustments are needed to achieve success. When actions do result in demonstrable improvements, those actions will be spot-lighted and celebrated.

Highlights of success stories will be communicated on the Division website, in memos and other communiqués so that we can learn from each other. Sharing successes will encourage innovation and enable replication of successful practices.

Structure and Responsibilities of the Quality Management Program



Executive Leadership Team

Ultimate responsibility for comprehensive and sustainable quality management at DMH/DD/SAS rests with the Division's Executive Leadership. The Executive Leadership Team delegates operation of the quality management structure to the QM Steering Committee, which is chaired by the Division's Medical Director.

Quality Management Steering Committee

The QM Steering Committee is charged with the overall success of the Division's quality management initiatives. It oversees all quality management responsibilities in the Division and serves as the hub receiving reports and recommendations from the Quality Cross-Functional Sub-Committees, coordinates quality improvement initiatives with the Executive Leadership Team and sub-committees as needed, facilitates communications related to quality improvement activities and initiatives within the Division, and it serves as the link to other DHHS quality initiatives. The QM Steering Committee is responsible for promoting excellence and for identifying potential problems and opportunities for improvement and ensuring that they are

referred to and addressed at the appropriate level within the organization. The QM Steering Committee ensures that corrective action and quality initiatives are followed-up to ensure successful resolution and keep the Executive Leadership Team informed.

Quality Cross-Functional Committees

The QM Steering Committee delegates priority quality improvement initiatives to specialized Quality Cross-Functional Committees with expertise in clinical quality, consumer health and safety, LME performance, data analytics, statewide initiatives, system coordination, finance and self-evaluation. Several Committees also have workgroups that address specific topics within the purview of the Committee. Each committee and its workgroups are responsible for monitoring and providing oversight of specific areas within its charge and identifying potential problems or opportunities for improvement. Each committee regularly reports to the Quality Management Steering Committee its activities, any areas of concern and success it has identified, and provides recommendations for action to improve the service system. Each committee monitors the results of corrective action and quality initiatives within its purview to ensure successful resolution and keeps the QM Steering Committee informed.

Time Limited Workgroups

Time-limited workgroups will be established as needed to address a specific issue, formulate a recommendation for an appropriate course of action, or implement a particular initiative. Membership will be drawn from staff with relevant experience and skills. Each group will have a charge that specifies a facilitator, the accountable staff persons, deliverables, timelines and routes of communication.

Quality Management Program Committees & Initiatives

Quality Management Steering Committee

Reports To: Executive Leadership Team	Chair: Medical Director
Responsibilities: <ol style="list-style-type: none"> 1. Develops and manages implementation of annual Quality Management Plan with improvement initiatives and expected outcomes. 2. Tracks key indicators of quality and progress on performance goals. 3. Reviews regular reports on the quality initiatives and identifies emerging issues and opportunities. 4. Coordinates the work of cross-functional committees and time-limited workgroups. 5. Receives recommendations from cross-functional committees for system improvements, develops proposals to address emerging issues and opportunities to improve quality, oversees implementation of initiatives and evaluates the impact of those initiatives. 6. Supports development of staff's capacity to use QM approaches in daily activities. 7. Conducts annual self-evaluations of the quality structure's impact and areas for improvement. 	
Membership: <p>Medical Director Quality Management Team Leader Best Practice Team Leader Chairs of Cross-Functional Quality Committees Representatives selected from: Advocacy and Community Services Section, Clinical Policy, Operational Support Section, Accountability Team, Budget Team, IT Services, Best Practice Team, Prevention and Early Intervention Team, Justice Innovations Team, Quality Management Team, LME Performance Team & Division of State-Operated Health Facilities (DSOHF)</p>	
Linkages: <p>DHHS Excels Committee & Workgroups DHHS Quality Committee</p>	QM Subcommittees: <p>Clinical Quality Consumer Health & Safety Crisis Coordination Data Analytics Finance LME Performance Statewide Initiatives System Coordination Division Self-Evaluation</p>
	Meeting Schedule: <p>Monthly and as needed</p>

Quality Management Steering Committee Continued

Influencing Factors:

1. On April 3, 2013, NC Governor Pat McCrory released "A Partnership for a Healthy North Carolina," a framework for Medicaid reform to improve care, customer service and results for North Carolina's young and elderly, disabled, mentally ill and low-income families.
2. In January 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided states a draft copy of the National Behavioral Health Quality Framework to guide discussion and development of performance indicators for mental health and substance abuse services in line with the National Quality Strategy of the U.S. Department of Health and Human Services (U.S. HHS).
3. On March 21, 2011 the U.S. HHS released the National Strategy for Quality Improvement in Health Care, a report to Congress designed to make health care more affordable, patient-centered, and safe.
4. In June 2010, SAMHSA's Center for Mental Health Services held a conference with representatives from all states to discuss strategic initiatives in response to health care reform. As a result, SAMHSA established eight Strategic Initiatives to improve the delivery and financing of prevention, treatment and recovery support services to advance and protect the Nation's health.
5. In the fall of 2010, DHHS engaged Mercer Government Human Services Consulting (Mercer) to conduct an organizational review of its oversight of Medicaid behavioral health programs. The Division's intent was to enhance its quality monitoring skills related to the expanded oversight of the behavioral health Medicaid services provided through the LMEs as managed care organizations.

Current Priority Initiatives Delegated To QM Committees:

1. Improved clinical and programmatic support for appropriate use of crisis services and community response to crisis service needs.
2. Strengthen Assertive Community Treatment Team services by revising the ACTT service definition to meet evidence-based requirement standards of the Dartmouth Model.
3. Strengthen Supported Employment services by meeting evidenced based requirements per the SAMHSA implementation toolkit and other national models.
4. "Bring Them Home" Initiative focuses on returning 300 children placed in out-of-state psychiatric residential treatment facilities (PRTFs) and reducing the lengths of stay in out-of-home placements.
5. Guide the development and implementation of the Medicaid 1915 b/c Waiver.

Clinical Quality Committee

This committee is charged with monitoring and improving clinical services and supports, including consumers' access, service gaps and quality, and adoption of evidence-based practices.

Reports To: Quality Management Steering Committee	Chair: Best Practice Team Leader or designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Conduct regular reviews of patterns and trends in key indicators and report summaries to the QM Steering Committee. 3. Provide guidance to LME/MCOs and providers on questions about clinical policy, as needed. 4. Identify emerging issues in the quality of services and make recommendations for action to the QM Steering Committee. 	
Membership: <p>Clinical staff representatives for each age-disability group drawn from:</p> <ul style="list-style-type: none"> • Best Practice Team • Justice Systems Innovations Team • Prevention and Early Intervention Team • Office of Clinical Policy • Other teams, as needed <p>Accountability Team representative DSOHF NC-TOPPS Manager National Core Indicators Manager</p>	
Linkages: <p>Provider-LME Leadership Forum DHHS Excels Goal Teams State Epidemiology Workgroup</p>	Cross Functional Workgroups: <p>Child System of Care</p>
	Meeting Schedule: <p>Monthly and as needed</p>
Influencing Factors: <p>The Affordable Care Act (ACA) promotes the integration of behavioral health and primary health care. This integration results in improved access and improved quality of services for those in need of behavioral healthcare. The goals for healthcare reform and the State's expansion of the 1915 b/c waiver are similar in that they both focus on cost containment while focusing on increased quality, access, and prevention to improve care.</p>	

Clinical Quality Committee Continued

Current Initiatives:

1. Improved clinical and programmatic support for appropriate use of crisis services and community response to crisis service needs.
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3. Strengthen Supported Employment services by meeting evidenced based requirements per the SAMHSA toolkit and other national models.
4. “Bring Them Home” Initiative focuses on returning 300 children placed in out-of-state PRTFs and reducing the lengths of stay in out-of-home placements.
5. Development of child residential services to include evidence based practices recommendations or mandates.

Consumer Health & Safety Committee

Formerly known as the Incident Quality Review Committee, this committee is charged with monitoring and ensuring improvements in response to consumer adverse events. The Consumer Health and Safety Committee is being expanded to also monitor and improve response to consumer complaints, monitoring of medications and NC population health and safety issues.

Reports To: Quality Management Steering Committee	Chair: Customer Service and Community Rights Team Leader or designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Conduct regular reviews of patterns and trends in complaints, appeals, consumer incidents, prescription monitoring and NC health indicators and report summaries to the Quality Management Steering Committee. 3. Identify emerging issues and make recommendations for action to the QM Steering Committee. 4. Provide guidance to LME/MCOs on response to individual complaints and incidents, as needed. 	
Membership: <ul style="list-style-type: none"> Customer Service and Community Rights Team representative Division Affairs Team representative Accountability Team representative State Opioid Treatment Authority Division Pharmacist Controlled Substances Reporting System representative Clinical staff representatives for each disability 	
Linkages: <ul style="list-style-type: none"> DSOHF (Patient Safety & Incident Reporting) DHSR Mental Health Licensure Section State Epidemiology Workgroup Disaster Preparedness staff 	Cross Functional Workgroups: None at this time
	Meeting Schedule: Monthly and as needed
Influencing Factors: <ul style="list-style-type: none"> Data from NC Incident Response and Improvement System (IRIS) Data from Quarterly LME/MCO Complaint Reports 	
Current Initiatives: <ol style="list-style-type: none"> 1. Decrease deaths in Opioid Treatment Programs 2. Decrease the use of restrictive interventions 3. Suicide prevention 	

Crisis Committee

This committee is charged with monitoring and improving the array of crisis services and supports, including consumers' access, service gaps and quality in an effort to divert individuals from using the emergency departments for behavioral health crisis episodes.

Reports To: Quality Management Steering Committee	Chair: Community Policy Management designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Conduct regular reviews of patterns and trends in key indicators and report summaries to the QM Steering Committee. 3. Provide guidance to LME/MCOs and providers on questions about crisis services, as needed. 4. Identify emerging issues in the quality of services and make recommendations for action to the QM Steering Committee. 	
Membership: Medical Director Community Policy Management, Chief Best Practice Team Leader Representatives selected from: Advocacy and Community Services Section, Clinical Policy, Operational Support Section, Accountability Team, Budget Team, Best Practice Team, Prevention and Early Intervention Team, Justice Innovations Team, Quality Management Team, LME Performance Team & Division of State-Operated Health Facilities (DSOHF)	
Linkages: Provider-LME Leadership Forum DHHS Excels Goal Teams State and Community Hospitals	Cross Functional Workgroups: Three-Way Contract Hospital Beds
	Meeting Schedule: Monthly and as needed
Influencing Factors: Legislation & appropriations for 3-way beds and enhanced (tiered rate) Statewide effort to divert use of EDs for behavioral health crisis Need to reduce the number of people with repeated crisis events, and to enhance and expand community based, non-hospital care Access to reliable reporting and claims data	
Current Initiatives: <ol style="list-style-type: none"> 1. Increase the use of Telepsychiatry statewide in EDs 2. Increase the use of Walk-In Crisis services to divert from using ED for behavioral health crisis. 3. Improve Mobile Crisis Management services to divert from using ED for behavioral health crisis. 4. Reduce ED admissions and wait times. 	

Data Analytics Committee

This existing committee's charge is being expanded to include responsibility for monitoring and improving data availability, quality and reporting across all data systems of the Division and linkages to other DHHS data systems.

Reports To: Quality Management Steering Committee	Chair: Quality Management Team designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Monitor advances and revisions to DMH/DD/SAS data warehouses and related technologies to ensure coordination and maximize integration through communication and strategic planning. 3. Promote principles that DMH/DD/SAS data sources are comprehensive, accurate, timely, standardized, verifiable, and accessible, integrated and undergo continuous quality improvement. 4. Ensure that data for internal and external reporting are accurate, consistent and understandable. 5. Address data collection and performance measurement issues for Division and Department leadership. 6. Provide guidance on questions about data collection, analysis and reporting, as needed. 7. Monitor data warehouse access and IT development in other state and local agencies. 8. Identify emerging issues and make recommendations for action to the QM Steering Committee. 	
Membership: <p>Data Operations Team representatives</p> <p>Accountability Team representative</p> <p>Budget Team representative</p> <p>Quality Management Team representatives</p> <p>Representatives for all major Division data systems, including:</p> <ul style="list-style-type: none"> • Consumer Data Warehouse (CDW) • Integrated Payment and Reporting System (IPRS) • Medicaid Management Information System / NC TRACKS • NC-TOPPS • Incident Response Improvement System (IRIS) • HEARTS 	
Linkages: <p>OMMIS</p> <p>DMA Drive Team</p> <p>NCCCN Informatics Center</p> <p>DHHS Health IT Committee</p>	Cross Functional Workgroups: <p>CDW Revisions Workgroup</p> <p>IPRS Workgroup</p> <p>Truven Consulting</p> <hr/> Meeting Schedule: Monthly and as needed

Data Analytics Committee Continued

Influencing Factors:

Conversion to NC TRACKS & Truven Reporting and Analytics
Integrity and validity of LME/MCO data

Current Initiatives:

1. Identify reports affected by the changes in claims processing since implementation of MCO functions and the changes to the state IT system.
2. Plan for the transition to NCTRACKS and Truven; prioritize the development of databases and reports.
3. Educate the committee on external data sources relevant to MH/DD/SAS.
4. CDW revisions required for July 2014.

Finance Committee

This committee has oversight of the appropriate use of administrative and service funds by LME/MCOs and contractors, as outlined in NC General Statute 122-C.

Reports To: Quality Management Steering Committee	Chair: Budget Team designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Oversee reporting of expenditures of block grant funds and state allocations. 3. Develop recommendations for LME/MCO expenditure reporting. 4. Conduct regular reviews of patterns and trends in LME/MCO expenditures and report summaries to the QM Steering Committee. 5. Inform LME liaisons of identified problems. 6. Provide guidance to LME liaisons on questions about specific LME/MCO requirements, as needed. 7. Identify emerging issues and make recommendations for action to the QM Steering Committee. 	
Membership: <ul style="list-style-type: none"> Budget Team representatives Resource & Regulatory Management Chief or designee Quality Management Team representative Data Operations Unit representative Community Policy Management Chief or designee 	
Linkages: NC Office of the Controller	Cross Functional Workgroups: None at this time
	Meeting Schedule: Monthly and as needed
Influencing Factors: DMH/DD/SAS has system oversight of: <ul style="list-style-type: none"> • Fiscal Monitoring and Audits (Block Grant, Medicaid, Designated State Appropriations) 	
Current Initiatives: <ol style="list-style-type: none"> 1. Explore rebasing the prevention portion of the block grant. 2. Implementation of the LME-MCO Efficiency Plan. 3. Development and implementation of LME/MCO Business Plan procedure. 	

LME Performance Committee

Formerly known as the Knowledge Management Group, this committee is charged with monitoring and ensuring compliance with requirements for use of state & federal block grant funds and LME contracted functions.

Reports To: Quality Management Steering Committee	Chair: LME Performance Team Leader or designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Oversee adherence funders and performance requirements. 3. Development and implementation of LME/MCO Local Business Plan review process. 4. Develop recommendations for LME performance measures. 5. Conduct regular reviews of patterns and trends in LME performance and report summaries to the QM Steering Committee. 6. Inform LME liaisons of identified problems. 7. Provide guidance to LME liaisons on questions about specific LME requirements, as needed. 8. Identify emerging issues and make recommendations for action to the QM Steering Committee. 	
Membership: <ul style="list-style-type: none"> LME Performance Contract managers MH and SAPT Block Grant planners Special Program managers Accountability Team representative Consumer Empowerment Team representative Data Operations Unit representative Quality Management Team representative Budget Team representative Customer Service & Community Rights Team representative 	
Linkages: <ul style="list-style-type: none"> LME/MCO Provider-LME Leadership Forum Intra-Departmental Monitoring Teams 1915 b/c Medicaid Waiver Leadership 	Cross Functional Workgroups: <ul style="list-style-type: none"> None at this time
	Meeting Schedule: <ul style="list-style-type: none"> Monthly and as needed
Influencing Factors: <ul style="list-style-type: none"> Coordination of DMA and DMH/DD/SAS Contract expectations 	
Current Initiatives: <ol style="list-style-type: none"> 1. Development and implementation of LME/MCO Business Plan procedure 2. Development and implementation of sub-recipient monitoring procedure 3. Provide guidance tools to LMEMCOs for adherence to block grant funds and state allocation requirements 	

Statewide Initiatives Committee

This committee is charged with ensuring the provider capacity and quality of the Cross-Area Service Programs (CASPs), appropriate use of Block Grant funds, and other statewide programs for targeted populations and/or services.

Reports To: Quality Management Steering Committee	Chair: Chief of Community Policy Management or designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Conduct regular reviews of patterns and trends in implementation of state service initiatives and findings of quality audits and reviews and report summaries to the QM Steering Committee. 3. Conduct regular reviews of service capacity, utilization, expenditures and coordination. 4. Provide guidance on questions about provider requirements, as needed. 5. Identify gaps in provider capacity and emerging issues and make recommendations for action to the QM Steering Committee. 	
Membership: <ul style="list-style-type: none"> Chief of Community Policy Management Accountability Team representative LME Performance Team representative Program Managers responsible for targeted service initiatives Federal Block Grant Subject Matter Experts Budget Team representative 	
Linkages: <ul style="list-style-type: none"> MH Block Grant Planning Council Substance Abuse Federation LME/MCO System of Care LME/MCO SA Points of Contact 	Cross Functional Workgroups: <ul style="list-style-type: none"> Block Grant Planning Workgroup
	Meeting Schedule: <ul style="list-style-type: none"> Monthly and as needed
Influencing Factors: <p>DMH/DD/SAS has system oversight related to:</p> <ul style="list-style-type: none"> • Licensure, Certification and Accreditation • Assurance of health and safety • UM/UR/Quality of Care • Fiscal Monitoring and Audits (Block Grant, Medicaid, Designated State Appropriations) • Monitoring of LME Compliance • Monitoring of Provider Compliance • Monitoring of other Division sub-recipients (contractors) • Remediation (Plans of Correction & Sanctions) • Investigations • External reviews of DMH (SAMHSA, CMS, Legislature, DHHS Excels, State Auditor) • Division self-monitoring • External sanctions on DMH • Response to complaints (from Consumers, Providers & LMEs) • Response to “concern” calls 	

Statewide Initiatives Committee Continued
Statewide Initiative Committee Current Initiatives: <ul style="list-style-type: none">1. Block Grant Plan.2. Explore rebasing the prevention portion of the block grant, in collaboration with the finance committee.3. Explore contingency management (rewards incentives) for consumers that meet specified treatment outcomes.4. Follow up on block grant review results to ensure compliance and explore implementation of recommendations.

System Coordination Committee

This committee is charged with managing coordination of services with the justice system, Division of Aging and Adult Services, Division of Health Services Regulation, Division of Public Health, Department of Public Instruction, Division of State Operated Healthcare Facilities, Division of Social Services, Division of Vocational Rehabilitation Services and other government agencies, as needed, to improve care for persons with MH/DD/SA disabilities. Committee will promote effective coordination and collaboration within the system of community services.

Reports To: Quality Management Steering Committee	Chair: Justice System Innovations Team Leader or designee
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Conduct regular reviews of provider compliance issues and service coordination patterns and identify gaps in provider capacity. 3. Provide guidance on questions about provider requirements, as needed. 4. Identify emerging issues and make recommendations for action to the QM Steering Committee. 	
Membership: <ul style="list-style-type: none"> Justice System Innovations Team Leader Accountability Team representative Best Practice Team representative Clinical Policy Office representative Customer Service and Community Rights Team representative Justice Systems Innovations representative LME Performance Team representative Operation Supports Section representative Prevention & Early Intervention Team representative System of Care representative DSOHF representative 	
Linkages: <ul style="list-style-type: none"> DMH-DSOHF Coordination Group DHHS IMD/PCS/DOJ Workgroup State Epidemiology Workgroup 	Cross Functional Workgroups: <ul style="list-style-type: none"> None at this time
	Meeting Schedule: <ul style="list-style-type: none"> Monthly and as needed
Influencing Factors: <ul style="list-style-type: none"> Department of Justice Settlement Implementation of Medicaid reform plan 	
Current Initiatives: <ol style="list-style-type: none"> 1. Review current DMH/DD/SAS system coordination partnerships to develop and guide collaborative efforts for waiver implementation. 2. Identify emerging issues and make recommendations regarding cost shifting to other service systems. 3. Evaluate LME functions outside of the waiver to ensure important system coordination functions are not lost in the shift to CCEs. 	

Division Self-Evaluation Committee

This committee will be established as part of the SFY2013 Quality Management Plan to be responsible for ensuring Division compliance with funders' requirements, building a quality improvement culture within the Central Office and ensuring that Division staff have input into improving Division operations.

Reports To: Quality Management Steering Committee	Chair: Selected by membership
Responsibilities: <ol style="list-style-type: none"> 1. Implement approved improvement initiatives delegated by QM Steering Committee and sets goals, objectives, and strategies to meet expected outcomes and report progress and results back to the QM Steering Committee. 2. Conduct internal audits to ensure compliance with funders' requirements and report findings to QM Steering Committee. 3. Identify internal Central Office issues that impact the quality of care in the service system and Division operations, and make recommendations for action to the QM Steering Committee. 	
Membership: Representatives for all Division teams	
Linkages: Management Leadership Team	Cross Functional Workgroups: None at this time
	Meeting Schedule: Monthly and as needed
Influencing Factors: Block Grant Requirements DHHS Excels State Auditor requirements/expectations	
Current Initiatives: <ol style="list-style-type: none"> 1. Establish a mechanism for review of DMH/DD/SAS policies and procedures on an annual basis to ensure compliance with funder requirements. Policies should reflect DHHS excels values and promote effective and efficient use of DMH/DD/SAS resources. 2. Establish an ongoing internal communication mechanism for promoting DMH/DD/SAS goals, service and performance initiatives and recognizing achievements. 	